

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

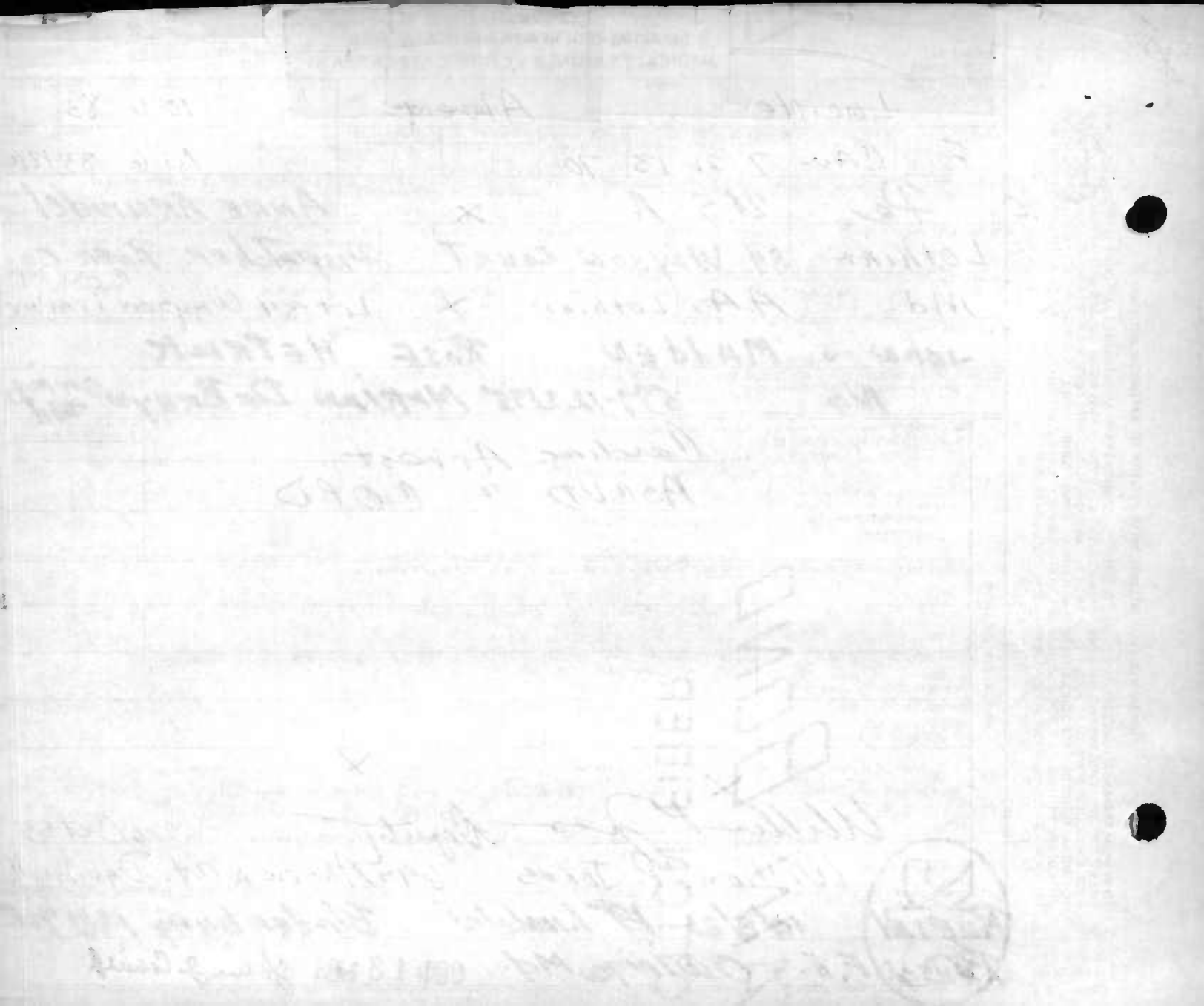
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Lucille Alvey		10 6 1983		12 18	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
F	CAU	7 21 13	70 RS.	MONTHS	DAYS
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pa	U.S.A	NEVER MARRIED		ANNE ARUNDEL	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
Lothian		84 Wayson Court		Dispatcher Power Co	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Md.		A.A. Lothian		20711 Lot 84 Wayson Trailer	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
John J. Madden		Rose Hetrick		579-122195	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		18. CAUSE OF DEATH	
NO		MARIAN De Bryn		Cardiac Arrest	
19. IMMEDIATE CAUSE (a)		19. IMMEDIATE CAUSE (b)		19. IMMEDIATE CAUSE (c)	
4292		ASCVD & COPD			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY		21f. LOCATION	
		(AT HOME, STREET, FACTORY, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
William P. Jones		Deputy Medical Examiner		6 Oct 83	
EXAMINER'S NAME		ADDRESS		23a. DATE REC'D. BY REGISTRAR	
(TYPE OR PRINT) William P. Jones		695 America Ct. Davidsonville		1 3 1983	
23. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/8/83		Bladenburg Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ransch F. B. Owings, Md.		1 3 1983		John J. Conner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all blank pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				83 25675			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANORE L ANDERSON				2a. DATE OF DEATH MONTH DAY YEAR 10 28 83		2b. HOUR 7⁵⁰ PM	
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 15 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR IF UNDER 74 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home				12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE MD.				13b. COUNTY AA			
14. FATHER'S NAME FIRST MIDDLE LAST Harry R Cooke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Emery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-03-2607D			
17. INFORMANT ADDRESS Eleanore A. Hemmick #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4225 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. R. Liechtenstein				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. Liechtenstein				22e. ADDRESS 20 Ridgeby Ave Annapolis, MD.			
23a. BURIAL, CREMATION, REMOVAL (TYPE) CREMATION		23b. DATE 10/30/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Southland P.G. MD.	
24. FUNERAL DIRECTOR Taylor Funeral Chapel				25a. DATE REC'D. BY REGISTRAR OCT 31 1983			
25b. REGISTRAR'S SIGNATURE [Signature]							

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 0 7 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST PATRICIA ANGELA BARBOUR			2a. DATE OF DEATH MONTH DAY YEAR 10-21-83		2b. HOUR MIN 5⁴⁴ A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1951		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Development Specialist		
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Churchton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1232 Ellicott Ave. 20733	
14. FATHER'S NAME FIRST MIDDLE LAST Edward L. Corbi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Joanna Mercure			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-52-3782		17. INFORMANT ADDRESS Deniel H. Barbour Same as # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic Breast Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**1 year**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE E. W. Cole		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/21/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE		22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/2483	23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balt. Md.
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25a. DATE REC'D. BY REGISTRAR OCT 25 1983	25b. REGISTRAR'S SIGNATURE John J. Connel
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• 02jun3 15:20:50

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1- STATE REGISTRAR							2a. DATE KNOWN OF DEATH					2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE BARNER							2c. DATE KNOWN OF DEATH ESTIMATED 10 19 1983					2d. HOUR 5:27 PM	
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 17 51		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 10 19 1983		7d. HOUR 5:27 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.				
10 CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE Virginia			13b. COUNTY			13c. CITY OR TOWN Norfolk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2801 Colonial Avenue 23508			
14. FATHER'S NAME FIRST MIDDLE LAST George Winfield					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Barner					17. INFORMANT ADDRESS Apt. 4			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 230-68-6335			17. INFORMANT ADDRESS Mattie Burroughs 815 E. 29th St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR P.M. 10-19- 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11 Marcs Ct. Annapolis, Anne Arundel, Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 10-20-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 11/1/83		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Norfolk, VA.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Ave.						25a. DATE REC'D. BY REGISTRAR NOV 1 1983		25b. REGISTRAR'S SIGNATURE John J. Ganiel					

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



RECEIVED
JAN 10 1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lillian M. Battle			2a. DATE OF DEATH MONTH DAY YEAR October 19, 1983		2b. HOUR 6:20P.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 10 6 09	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen'l Hospital		12a. USUAL OCCUPATION (TYPE OR WORK, FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY A.A.	13c. CITY OR TOWN Crofton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James P. Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian M. Hyatt		13e. STREET ADDRESS / ZIP CODE 1813 Regents Park Road E. Zip Code -21114	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-76-0053		17. INFORMANT ADDRESS Mrs. Helene Hill Address Same as No# 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) 2% Ischemic cardio myopathy DUE TO, OR AS A CONSEQUENCE OF (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 1981 , 19 85 , to OCT 19 , 19 85 , that (I) (we) lost saw the deceased alive on OCT 19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE BARRY R. NATHANSON		DEGREE MD		22c. DATE SIGNED 10/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON		22e. ADDRESS 51 FRANKLIN ST. ANNAP, MD. 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 22, 1983	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 24 1983		25b. REGISTRAR'S SIGNATURE John J. Gough	

BP _____

October

Washington, D.C.

Dear Sirs

Mr. C. C. - 2111

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph Albert Beall			2a. DATE OF DEATH MONTH DAY YEAR 10-24-83			2b. HOUR 8:00AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 9, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Odenton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 Denson Drive		12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) Electrical Construction Worker		12b. KIND OF BUSINESS OR INDUSTRY Private Company	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton	
14. FATHER'S NAME FIRST MIDDLE LAST William Leo Beall, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith May Simpson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unk.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Margaret M. Beall-104 Denson Drive Odenton, Md. 21144			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Malesstic Cancer**
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) **Epiconast Squamous cell ca**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-8 , 19 82 , to 10-24 , 19 83 , that (I) (we) lost saw the deceased alive on 10-24-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony M Caputo M.D.				22e. ADDRESS 132 Holiday Ct. Ste 201 Annapolis Md 21401			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/83		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens Davidsonville (A.A.) Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Richard A. Coleman - Upper Marlboro, Maryland 20772				25a. DATE REC'D. BY REGISTRAR OCT 31 1983			
				25b. REGISTRAR'S SIGNATURE [Signature]			

William Lee Hall, Sr.
Morgan M. Hall-Donner
Jill Donner

[illegible]

101 Benson Drive

100-100000

● ● ●

24

0.25

C.I.M.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HAROLD A. BEITZEL										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 24 1983	
3. SEX Male		4. RACE Can		5. DATE OF BIRTH MONTH 12 DAY 9 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		2b. HOUR 0112	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAGH.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Correctional Officer			12b. KIND OF BUSINESS OR INDUSTRY District of Columbia Jail		
13a. STATE Md.			13b. COUNTY AA		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 402 Fairmount Dr.		
14. FATHER'S NAME FIRST Henry MIDDLE J. LAST Beitzel					15. MOTHER'S MAIDEN NAME FIRST Cynthia MIDDLE Snyder LAST 21037						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT ADDRESS Wayne H. Beitzel 4723 Washington Av Shadyside, Md. 20764					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones						TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones						ADDRESS 695 America Ct 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 10-24-83		23c. NAME OF CEMETERY OR CREMATORY Green County Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Jefferson Greene Penn.			
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS ADDRESS 1212 WEST ST. ANNAPOLIS						25a. DATE REC'D. BY REGISTRAR OCT 21 1983 25b. REGISTRAR'S SIGNATURE Jan J. Carver					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		10-5-83		10:10 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		3-24-1895		88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. WIDOWED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTO. CO.		U.S.A.				ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SEVERNA PARK		48 CEDAR RD.		HOUSEWIFE		HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD.		A.A. CO.		SEVERNA PARK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		48 CEDAR RD. 21146			
GUSTAV		KAEEMMEL		AUGUSTA		PERSHINSKI	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		213-74-6671		ELIJAH LIEB		SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1970</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>70</u> , to <u>OCT 5</u> , 19 <u>83</u> , that (I) was lost		22b. SIGNATURE <u>Francis I. Codd</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>10-6-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
FRANCIS I. CODD M.D.		P.O. BOX 627, SEVERNA PARK, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		10-7-83		WESTVIEW CREM		BALTO MD.	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
ROBERT S. BARRANCO		SEVERNA PARK				OCT 1 1 1983	

Item 17 (Per call from F.H. 11/1/83)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) August			2a. DATE OF DEATH MONTH DAY YEAR Oct. 30 1983			2b. HOUR 4 P M	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.	
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Conval.Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner operator	
12b. KIND OF BUSINESS OR INDUSTRY Marina		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					
13b. COUNTY A.A.		13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6333 Genoa Rd. 20751	
14. FATHER'S NAME FIRST MIDDLE LAST August Berlitz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.2		17. INFORMANT ADDRESS Berlitz Marjorie C. Berlitz same as 13e.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary Sepsis 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Prostate DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS 3+ years	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Atrial Fibrillation; Gen. Arteriosclerosis; Bow Melastases -

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from 1979, 1983, to Present, that (I) (we) saw the deceased alive on 11-28-83, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

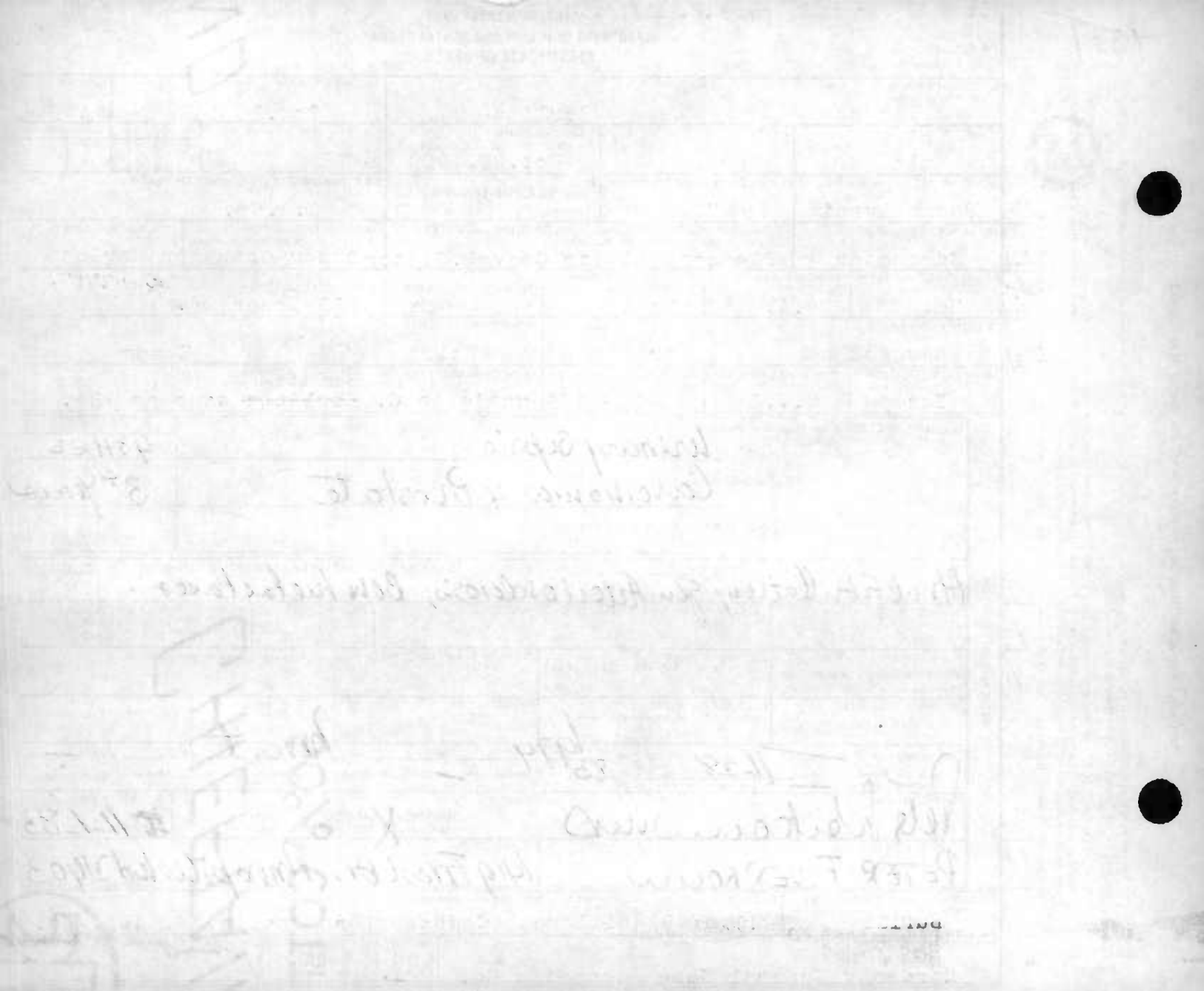
22a. SIGNATURE Peter F. Verkauw		DEGREE		22c. DATE SIGNED 11-1-83	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKAUW		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. ADDRESS 1419 Forest Dr. Annapolis Md 21403	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/2/83		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Md. A.A.Co.	
24. FUNERAL DIRECTOR NAME Hardesty Funerals Home Annapolis Md.				25a. DATE REC'D. BY REGISTRAR NOV 01 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.		EDT	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE A BERTRAM				MONTH DAY YEAR OCTOBER 03, 1983		1125 AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12/26/1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Whatcheer, Iowa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT THROUGH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY Broker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1571 Eaton Way	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Crofton		13f. STREET ADDRESS 1571 Eaton Way	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Alt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Mae McKeen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. ----- 341-20-8646		17. INFORMANT ADDRESS Mrs Richard Strauss Crofton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Fred T. Kahn M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRED T. KAHN, M.D.		22e. ADDRESS 7575 RITCHIE HIGHWAY SE, GLEN BURNIE, MD. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/5/83		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, Md. A.A. Co.	
24. FUNERAL DIRECTOR NAME Hardesty Fuenral Home		ADDRESS 12 Ridgely Ave Annapolis, Md. 20401		25a. DATE REC'D. BY REGISTRAR OCT 10 1983		25b. REGISTRAR'S SIGNATURE J. C. C. C.	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK M. BINGEL			2a. DATE OF DEATH MONTH DAY YEAR Oct 9, 1983		2b. HOUR M AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov 20, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Home - Anne Arundel Co. MD
10 CITY OR TOWN OF DEATH Riviera Bch		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home-8571 Bay Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Freight
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Riviera Bch		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL BINGEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH KRISLER		17. INFORMANT ADDRESS 8571 Bay Rd. (21122)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-8517		17. INFORMANT ADDRESS Mary Emma Bingel (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of left lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-10-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A.Co., Maryland
24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR OCT 10 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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DHMH - 16 25M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret		FIRST Blamphin		LAST		2a. DATE OF DEATH MONTH 10 DAY 27 YEAR 83		2b. HOUR 4:50 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH FEB. DAY 10 YEAR 1884		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOLIS CONVELESCENT HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 650 MAGATHY VIEW 21012	
14. FATHER'S NAME FIRST EVAN MIDDLE J. LAST THOMAS		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE ANN LAST PHILLIPS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-36-2584		17. INFORMANT ADDRESS CAPT. ARTHUR M. BLAMPHIN (SAME AS 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Breast Ca 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/18/83 to 10/27 , 19 83 , that (I) (we) last saw the deceased alive on 10/18/83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George Simaras		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Simaras		22e. ADDRESS 205 Ridgely Ave Annapolis							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 29, 1983		23c. NAME OF CEMETERY OR CREMATORY PHILADELPHIA MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE PHILADELPHIA CHESTER PA.			
24. FUNERAL DIRECTOR NAME Ronald S. Bonanno ADDRESS Severna Park		25a. DATE REC'D. BY REGISTRAR OCT 31 1983		25b. REGISTRAR'S SIGNATURE Joan J. Lander					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR					REG. NO.					EDT				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MATTIE E BOARDMAN					2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 21, 1983					2b. HOUR 1000 AM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 9, 1923			6. AGE (IN YEARS LAST BIRTHDAY) 60			IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie			13e. STREET ADDRESS 312 Highland Dr. 21061							
14. FATHER'S NAME FIRST MIDDLE LAST Aylett C. Fincham					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Burke									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 231-22-7545		17. INFORMANT ADDRESS Leo E. Boardman/husband Sams as 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic ovarian cancer DUE TO, OR AS A CONSEQUENCE OF (c) 18 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 83 , to 10-21 , 19 83 , that (I) (we) last saw the deceased alive on 10-20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.														
22b. SIGNATURE Long S. Hsu DEGREE M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Oct. 21, 1983						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.					22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Washington Masonic Cemetery, Rappahannock Co., VA			23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service Falls Church, VA														
25. DATE RECEIVED BY REGISTRAR OCT 27 1983														
25b. REGISTRAR'S SIGNATURE John J. Gough														

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Journal of Interpersonal Violence

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		Item 13 phone 10-28-83		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY E. BORDLEY				2a. DATE OF DEATH MONTH DAY YEAR 10 - 14 - 83	
3. SEX Female		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 7 22 29	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 54	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAGH		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD.	
18a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY QA		13c. CITY OR TOWN Stevensville	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Bordley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Saddie Sheppard		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P.O. BOX 421	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-26-1707		17. INFORMANT ADDRESS Saddie Greene Stevensville, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: 5570 IMMEDIATE CAUSE (a) Superior mesenteric artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse atherosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) paroxysmal atrial fibrillation				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days years 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Myocardial infarction, AODM					
19a. DATE OF OPERATION 10/13/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemic bowel disease		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/12 , 19 83 , to 10/14 , 19 83 , that (I) (we) last saw the deceased alive on 10/14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M. M. Mullins MD.		DEGREE		22c. DATE SIGNED 10/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MULLINS		22e. ADDRESS AAGen Hosp. Annapolis, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/15/83		23c. NAME OF CEMETERY OR CREMATORY BATHS NECK	
24. FUNERAL DIRECTOR (NAME) ERIC L. Dashiell		ADDRESS P.O. Box 606 EASTON, MD		25a. DATE REC'D. BY REGISTRAR OCT 24 1983	
25b. REGISTRAR'S SIGNATURE John J. Canish		25c. LOCATION CITY OR TOWN COUNTY STATE Stevensville QA MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph BOTTNER				2b. HOUR 10 13 83 8:35 P.M.			
3. SEX M.		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3-12-1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel City, MD.	
10. CITY OR TOWN OF DEATH Annapolis Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Jambills				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Paul Bottner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Krefenz Bottner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 212-36-7657		17. INFORMANT ADDRESS Chart, Nursing Home.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) STROKE, left sided 4360							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-1-83
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerosis							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senile dementia for ± 6 mos.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. certify that (this hospital) attended the deceased from 9-4 1983, to Present 19, that (we) lost the deceased alive on 10-13 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Peter F. VerKouwen MD				DEGREE		22c. DATE SIGNED 12-13-83	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUWEN MD				22d. ADDRESS 419 Forest Dr. Annapolis Md 21403			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/14/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 18 1983	
						25b. REGISTRAR'S SIGNATURE Joan J. Conish	



October

Friday

10/14/43

Removal

Baltimore, Md.

Anthony Board

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JUNE LAST BOWEN			2a. DATE OF DEATH MONTH 10 DAY 11 YEAR 83			2b. HOUR 1 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 6 DAY 7 YEAR 25		6. AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN'L				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASSIGNMENT CLERK CIP. TELEPHONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY H.A. 13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3 Cypress Rd. 21403					
14. FATHER'S NAME FIRST JAMES MIDDLE WINGHOW LAST DANIELS				15. MOTHER'S MAIDEN NAME FIRST MATTIE MIDDLE J. LAST HOPKINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 1- 219-12-3127		17. INFORMANT ADDRESS FRANCIS X. BOWEN #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (This hospital) attended the deceased from 9/30, 19 83, to 10/1, 19 83, that (1) (we) last saw the deceased alive on 10/1, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] MD			DEGREE COVERING FOR ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/1/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK TEITELBAUM MD			22e. ADDRESS 139 Old Schomars Ish. Rd. Englewood, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/4/83		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (CITY OR TOWN) ANNAPOLIS COUNTY AA MD		
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL ADDRESS ANNAPOLIS, MD.			25a. DATE REC'D. BY REGISTRAR OCT 4 1983		25b. REGISTRAR'S SIGNATURE [Signature]				

35 54 35 21 1

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Beatrice V. Brice				2a. DATE OF DEATH MONTH DAY YEAR October 22, 1983			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Annapolis				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21401 1811 Old Annapolis Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Wenceslaus J. Velenovsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Jankowski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 214-65-1259		17. INFORMANT ADDRESS Samuel McLean Brice - 84 Brice Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Resp. Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Indolent Carcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Indolent Carcinoma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE BARRY R. NATHANSON DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON				22e. ADDRESS 51 FRANKLIN ST. ANNAP., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis, MD				25a. DATE REC'D. BY REGISTRAR OCT 26 1983		25b. REGISTRAR'S SIGNATURE Charles G. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edward S Buckler Jr.				2a. DATE OF DEATH MONTH 10 DAY 6 YEAR 83 2b. HOUR 9 AM M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 5 DAY 23 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Liquor	
13a. STATE Md.		13b. COUNTY Annapolis		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Edward MIDDLE St. Clair LAST Buckler		15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE Cleveland LAST Insley		13e. STREET ADDRESS 680 Americana Drive 21403			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 216-03-8189		17. INFORMANT Eleanor ADDRESS Mrs. Eleanor H. Buckler (Same as #13.)			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE 2500 DUE TO, OR AS A CONSEQUENCE OF (b) HASVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) LDPM				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: G.H.F.							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 8/21 , 19 83 , to 10/6 , 19 83 , that (1) (we) last saw the deceased alive on 10/6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael J. LaPenta DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/6/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. LaPenta MD		22e. ADDRESS 703 GOODINGS AVE ANNAPOLIS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/6/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR OCT 11 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Bernard Carroll CARY, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR
October 11, 1983 | | 2b. HOUR
5⁴⁵ P^M |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
April 12, 1922 | 6. AGE (IN YEARS LAST BIRTHDAY)
61 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
AA Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7929 Elevation Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
mechanic | 12b. KIND OF BUSINESS OR INDUSTRY
machinery | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
AA Glen Burnie | 13c. STREET ADDRESS / ZIP CODE
7929 Elevation Rd. (21061) | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Cary | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Carroll | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
xxxxxxx 214/16/5941 | 17. INFORMANT ADDRESS
Gertrude A. Cary (wife) same as 13 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic carcinoma**
1890
DUE TO, OR AS A CONSEQUENCE OF
(b) **Carcinoma Kidney**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

| | | | |
|---|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1974 19____ to 10/11/83 19____, that (I) (we) lost
saw the deceased alive on 9/20/83 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (not) view the body after death. | | | |
| 22b. SIGNATURE
George B Ramirez | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
10/12/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE B RAMIREZ | | 22e. ADDRESS
7845 Oakwood Rd S205 Glen Burnie Maryland 21061 | |

| | | | |
|---|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Oct. 14, 83 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD |
| 24. FUNERAL DIRECTOR
NAME Singleton Funeral Home ADDRESS Glen Burnie, MD | | 25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE
OCT 13 1983 John J. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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1-
FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|-------------------------|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Valorie Jean Cates | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
10 17 19 83 | | | 2b. HOUR
M
4P | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 26, 1958 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
25 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
10 17 19 83 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alaska | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Ft. Meade | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kimbrough Army Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Book Store | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 264 Marganza So. 20707 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Floyd A. Cates | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellyne E. Erickson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No. | | | 16b. SOCIAL SECURITY NO.
213-80-2056 | | 17. INFORMANT
Floyd A. Cates | | | ADDRESS
same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetes Mellitus
2500
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 10 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . (SPECIFY) | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | | Deputy Chief MEDICAL EXAMINER | | | | | DATE SIGNED 10/18/83 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St. Balto, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
10/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
FLECK FUNERAL HOME, INC.
ADDRESS
7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | 25a. DATE REC'D BY REGISTRAR
OCT 19 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Cawich</i> | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Beverly C. Clark | | | 2a. DATE OF DEATH MONTH DAY YEAR
Oct. 24 1983 | | 2b. HOUR
1:21 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 3 1936 | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | |
| 10. CITY OR TOWN OF DEATH
GlenBurnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1606 Tieman Drive-GlenBurnie | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Factory Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Sluzewski | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen Lupaiko | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
213-32-9153 | 17. INFORMANT
3905 Misty View Rd.
Brenda Branham (dghtr) 21220 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
1950
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>head and neck cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
<i>William R. Redwood MD</i> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
10/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. William Redwood | | 22e. ADDRESS
Johns Hopkins-Outpatient Dept. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
10/27/83 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
OCT 25 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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10/10/10

10/10/10

10/10/10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 2 5 6 9 5
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Doris Booth Clarke | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-14-83 | | 2b. HOUR
1220 P |
| 3. SEX
female | 4. RACE
Cauc | 5. DATE OF BIRTH
MONTH DAY YEAR
07-29-16 | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen Hosp | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
CASHIER | 12b. KIND OF BUSINESS OR INDUSTRY
CAPITALS + LOAN | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
765 W. 111th St 21401 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert V. Booth | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle Hunt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-32-3064 | 17. INFORMANT
Frank E. Clarke. Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4912
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary fibrosis & emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic bronchitis | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immediate
many years
many years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.
Heart failure, Diabetes mellitus, Hypertension | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from August 24, 1970, to October 14, 1983, that (I) (we) last saw the deceased alive on Sept 27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Charles W. Kinzer | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Oct 14, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES W. KINZER, M.D. | | 22e. ADDRESS
16 MURRAY AVE, ANNAPOLIS, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Oct 17, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
St Anne's | |
| 23d. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel-Annapolis, MD | | 23e. ADDRESS
Annapolis, MD | | 23f. DATE RECEIVED BY REGISTRAR
OCT 18 1983 | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Robert V. Smith

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Frank L. Smith

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Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
GRACE Josephine Artz CLAUDE | | | | 2b. HOUR | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 13, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. STREET ADDRESS
52 Maryland Ave 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Oscar Mason Artz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Anne Ridenour | | 16. ADDRESS
110-B East St | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-32-3914 | | 17. INFORMANT
Gordon Handy Claude-Annapolis, MD 21401 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cholelith carcinoma</u>
1551
DUE TO, OR AS A CONSEQUENCE OF (b) <u>gram negative sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2-8</u> , 19 <u>83</u> , to <u>10-17</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>10-17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
GA Mitchell | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10-18-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GA Mitchell | | 22e. ADDRESS
205 Ridge Rd Annapolis | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Oct. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland PG. MD | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel - Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 21 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connelley | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rosalie Collins | | | | | | | | | | 2a. DATE KNOWN OF DEATH 10-9-83 | |
| 2b. HOUR 10:41 AM | | | | | | | | | | | |
| 3. SEX F | | | | | | | | | | 4. RACE white | |
| 5. DATE OF BIRTH 6-2-12 | | | | | | | | | | 6. AGE (IN YEARS) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE md. | | | | | | | | | | 13b. CITY OR TOWN Annapolis | |
| 13c. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | | 13d. STREET ADDRESS 164 Orchard Rd. Beach 21401 | |
| 14. FATHER'S NAME Robert | | | | | | | | | | 15. MOTHER'S MAIDEN NAME Lena Garrison | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Rae Caldwell | | | | | | | | | | ADDRESS 503 Forrest Rd. Riva MD 21140 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 9 Oct 83 | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 10/12/83 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | | | | | | | | | | 23d. LOCATION (CITY OR TOWN) Annapolis COUNTY FA MD. | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel ADDRESS Annapolis, MD | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR OCT 13 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | | | | | |

TO ONE

MD 424

MANAGER BARN

1957

12

Caroline H. H. H.

ASCD

x

Walter P. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

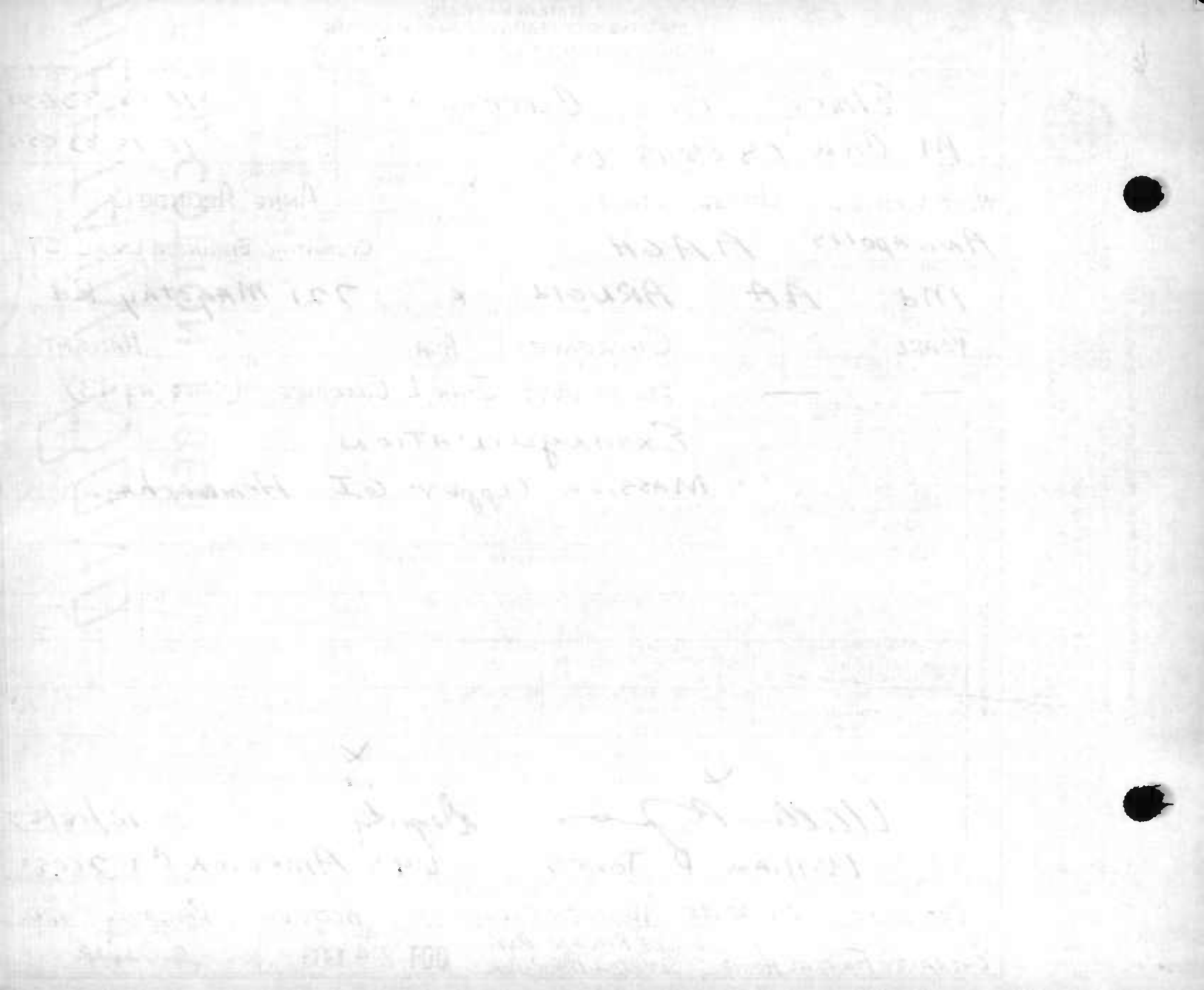
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--------|--|-----------------|---|--------------------------------|--|-----------------|---|-----------------|--|-------|--|-----------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Donald | | | | | | Cronin | | 10 20 83 | | | | | 12 ³⁰ P.M. |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| M | W | | 7 21 15 | | 68 YRS | | MONTHS | | DAYS | | HOURS | | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| California | | U.S.A. | | | | Anne Arundel County MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Annapolis | | Annapolis Conv. Ctr. | | Manager | | Advertising | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 21401 | | | |
| Md. | | AA | | Annapolis | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2570 -2507 Riva Road | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | |
| James | | Coop | | Cronin | | Lydia | | Von Falkenstein | | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 18b. SOCIAL SECURITY NO | | 19 INFORMANT | | 20a. DATE OF OPERATION | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20c. AUTOPSY? | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| No | | 455-01-2648 | | Mrs. Helen Cronin (Same as #13.) | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CEREBRAL ARTERIO-SCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 HOURS
10 YRS | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | 21g. DATE SIGNED | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21f. LOCATION | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | 21g. DATE SIGNED | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9-24-83 to 10-20-83, that (2) (we) last saw the deceased alive on 9-24-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22a. SIGNATURE | | EDWARD S. BECK MD. | | 22b. ADDRESS | | | | 10-20-83 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. REGISTRAR'S SIGNATURE | | | | | |
| Removal | | 10/20/83 | | | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Anatomy Board | | Balto., Md. | | OCT 27 1983 | | Re. E. Cronin | | | | | | | |

• 5M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE APPROVED BY THE JUDGE OF THE DISTRICT COURT IN WHICH THE DECEASED RESIDES. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 25699 | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Elmor F. Currence</u> | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
<u>10 18 83</u> | | 2b. HOUR
0315 M | |
| 3. SEX
<u>M</u> | | 4. RACE
<u>CAU</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>08 08 18 65</u> | | 6. AGE (IN YEARS)
LAST BIRTHDAY
<u>18 YRS.</u> | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>WEST VIRGINIA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>UNITED STATES</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>ANNE ARUNDEL</u> | | MD | |
| 10. CITY OR TOWN OF DEATH
<u>ANNAPOLIS</u> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>AAGH</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>OPERATING ENGINEER</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>LOCAL 37</u> | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
<u>MD.</u> | | 13b. COUNTY
<u>AA</u> | | 13c. CITY OR TOWN
<u>ARNOLD</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u>721 MAGOTHY RD.</u> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>PEARL</u> <u>CURRENCE</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>ASH</u> <u>HAUGHT</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
<u>232-20-5699</u> | | 17. INFORMANT
<u>JOHN L. CURRENCE</u> | | ADDRESS
<u>(SAME AS 13)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>EXSANGUINATION</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) <u>MASSIVE UPPER G.I. HEMORRHAGE.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE <u>William P. Jones</u> | | TITLE (SPECIFY)
<u>Deputy</u> | | MEDICAL EXAMINER | | DATE SIGNED <u>10/18/83</u> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>William P. Jones</u> | | ADDRESS <u>695 America Ct. 21035</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>CREMATION</u> | | 23b. DATE
<u>OCT. 20, 1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>WESTVIEW CREMATORY</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>WESTVIEW BALTIMORE MD.</u> | | | |
| 24. BURIAL DIRECTOR
NAME
<u>BARRANCO FUNERAL HOME</u> | | ADDRESS
<u>501 RITCHIE HWY. SEVERNA PARK, MD.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>OCT. 24 1983</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| FOR
STATE
REGISTRAR CHARLES L. DAVIDSON | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Lee Davidson | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
10 25 83 | | 2b. HOUR
0642 | | | |
| 3. SEX
m | | 4. RACE
Car | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 02 05 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
78 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
10 25 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK)
FOR <input type="checkbox"/> WORKING 1981
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Jacob Trans. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Rivera Bch | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
227 Asbury Rd. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles L. Davidson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Doyle | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
216-10-3058 | | 17. INFORMANT ADDRESS
Oscar Lowman (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
5118 Pulmonary Tuberculosis
IMMEDIATE CAUSE (a) Pulmonary Tuberculosis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
Hemothorax
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones | | | | TITLE (SPECIFY)
M.D. Deputy | | | | DATE SIGNED 10-25-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones MD | | | | ADDRESS 695 American Ct. 21035 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
10/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Balto., Md. 21225 | | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 0 1

1- FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Robert F DeBoy</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>10 1 83</i> | | | 2b. HOUR
<i>9:30 A.M.</i> | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>CAUCASIAN</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>08 31 06</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>77</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Anne Arundel General Hosp.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Construction</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Calvert</i> | | 13c. CITY OR TOWN
<i>Solomons</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>Box 123 20688</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Frank P. DeBoy</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary Ann Wheeler</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>NO</i> | | | | |
| 16b. SOCIAL SECURITY NO.
<i>216-07-7109</i> | | | 17. INFORMANT
<i>Dorothy Bowen</i> | | | ADDRESS
<i>P.O. Box 35 Huntingtown, Md. 20639</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>5849 IMMEDIATE CAUSE (a) Acute renal failure</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i> | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
<i>Adenocarcinoma of lung, caecal mass</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>9-7</i> , 19 <i>83</i> , to <i>10-1</i> , 19 <i>83</i> , that (2) (we) last saw the deceased alive on <i>9-30</i> , 19 <i>83</i> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) did (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>G A Mitchell</i> MD | | | | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>10-1-83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>G Mitchell MD</i> | | | | | 22e. ADDRESS
<i>205 Ridgely Ave Annapolis, Md 21401</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>10-3-1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Southern Mem. Gardens</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Dunkirk Calvert Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Donald V. Borgwardt</i> | | | | | ADDRESS
<i>Port Republic, Md. 20676</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 4 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-1-1951
SOUTHERN BELL TELEPHONE CO.
MEMPHIS, TENNESSEE
TO: J. Edgar Hoover, Director, FBI
FROM: J. Edgar Hoover, Director, FBI
SUBJECT: [Illegible]

10-1-1951
SOUTHERN BELL TELEPHONE CO.
MEMPHIS, TENNESSEE

[Extremely faint, illegible text covering the majority of the page, likely a teletype or heavily faded document.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES H. DICKERSON | | | 2a. DATE OF DEATH
MONTH 10 DAY 14 YEAR 83 | | | 2b. HOUR
7:25A M. | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Sept. DAY 19 YEAR 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secret Service | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
91 Beach Drive | |
| 14. FATHER'S NAME
FIRST CLARENCE A. MIDDLE DICKERSON LAST DICKERSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST CEDONIA MIDDLE BEALL LAST BEALL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-22-8048 | | 17. INFORMANT
Lydia Dickerson | | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Edgewater | | 13e. STREET ADDRESS
91 Beach Drive | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4960

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21i. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **SEPT 27**, 19 **83**, to **OCT 14**, 19 **83**, that (I) (we) lost
saw the deceased alive on **OCT 13**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTOR ☒STAFF
PHYSICIAN ☐

22c. DATE SIGNED

10/14/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

BARRY R. NATHANSON**51 FRANKLIN ST ANNAP. MD 21401**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Cremation**OCT 15, 1983****Westview Mem. Park****BALTIMORE MARYLAND**

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

H. F. Schmitt Owings Mills, Md.**OCT 18 1983****John J. Conner**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Mr. [Name] [Address]
[City] [State] [Zip]
Dear Sir:
[Faint, mostly illegible text body]

[Faint, mostly illegible text body]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR **DOROTHY A. DOHNER**

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Dorothy A. Dohner | | | 2a. DATE OF DEATH
MONTH 10 DAY 26 YEAR 83 | | | 2b. HOUR
M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 6 DAY 28 YEAR 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Brooklyn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5130 Brookwood Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY
Cleaners
Lord Balto. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Brooklyn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
5130 Brookwood Rd. (21225) | | | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE E. LAST Barnes | | | | 15. MOTHER'S MAIDEN NAME
FIRST Augusta MIDDLE D. LAST Hellman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-18-1264 | | 17. INFORMANT
Charlotte Kirkendall (same as 13a) | | | | ADDRESS | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Carcinomatosis
1830
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Ovarian Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 year
2 year | |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 19 81 to Oct 19 83 , that (I) (we) lost
saw the deceased alive on Sept October 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Philip Konits | | | | DEGREE
Attending Physician | | 22c. DATE SIGNED
10/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Philip Konits | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME Balto., Md. 21225
George J. Gonce F.H. 4001 Ritchie Hwy. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Laniel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|-------------------------|---|--|---|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY ESTHER DUGAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 11 83 | | 2b. HOUR
c 12 P M | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
01 31 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
HANOVER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1758 DORSEY ROAD, 21076 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CAR CLEANER | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
HANOVER | 13d. STREET ADDRESS
1758 DORSEY ROAD, 21076 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD REIMSNEIDER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE DORSEY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-22-3504 | | 17. INFORMANT
ADDRESS
FRANKLIN R. DUGAN 1758 DORSEY ROAD, 21076 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4100 ASH KD MT Sudden
IMMEDIATE CAUSE (a) 4100
DUE TO, OR AS A CONSEQUENCE OF (b) MYPER TENION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-6 19 83 to 6-27-83 that (I) (we) last saw the deceased alive on 6-27-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
George E. Groleau | | 22c. DATE SIGNED
10 13 83 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE E. GROLEAU, M.D. | | 22f. ADDRESS
5849 WASHINGTON BOULEVARD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-15-83 | | 23c. NAME OF CEMETERY OR CREMATORY
ZION CEMETERY | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELKRIDGE HOWARD MARYLAND | | 23e. DATE REC'D. BY REGISTRAR
OCT 14 1983 | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, IND. | | ADDRESS
4107 WILKENS AVE. | | 24b. REGISTRAR'S SIGNATURE
John J. Lauer | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | EDT | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ETHEL CRAIG DUNEY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 27, 1983 | | | | 2b. HOUR
120 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 5, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Florist | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS
506 Old Mill Rd. 21108 | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Millersville | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Kell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maude Lobley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
156-12-4331 | | 17. INFORMANT
ADDRESS
Martin DuneY same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
4960
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) COPD
DUE TO, OR AS A CONSEQUENCE OF
(c) COPD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/17/83 to 10/27/83 , that (I) (we) lost saw the deceased alive on 10/19/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Recep Erol | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RECEP EROL, M. D. | | | | 22e. ADDRESS
325 HOSPITAL DRIVE, SUITE 104
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
31 Oct. 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hammondton, Atlantic, N.J. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
James S. Kirkley F.H. Glen Burnie, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | | | | | |
| | | | | | | REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

BP

1977

| NAME | DATE | TIME | LOCATION |
|--------------|----------|-------|-----------|
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |
| JOHN A. WARD | 10/10/77 | 10:00 | ST. LOUIS |

RECEIVED
OCT 11 1977
FBI - ST. LOUIS



ST. LOUIS, MISSOURI
OCT 11 1977

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 / 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

ETD

| | | | | | | | | |
|---|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CALVIN H. EDGAR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 9, 1983 | | | 2b. HOUR
A M
8:00 | | |
| 3 SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 1, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
84 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
ARNOLD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
957 MAGOTHY AVE. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SELF EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY
ROOFER | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
ARNOLD | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
957 MAGOTHY AVE 21012 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY HARRY EDGAR | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY E. NEAL | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I | | 17. INFORMANT
ADDRESS
DOROTHY M. BROUGHTON (SAME AS 13) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the Prostrate
1850
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: () | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 81 , to 10/9 , 19 83 , that (I) (we) lost saw the deceased alive on 2 Sept , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (II) (we) did; (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
James Chaconas | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/9/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James Chaconas | | | | 22e. ADDRESS
1521 Ritchie Hwy Arnold MD 21012 | | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
OCT. 10, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WESTVIEW BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 13 1983 | | 25b. REGISTRAR'S SIGNATURE
James J. Carver | |

Handwritten notes and a table at the top of the page. The table has columns for 'Date', 'Time', and 'Remarks'. The text is mostly illegible due to blurriness and bleed-through.

Handwritten notes and a table at the bottom of the page. The table has columns for 'Date', 'Time', and 'Remarks'. The text is mostly illegible due to blurriness and bleed-through.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GLADYS M EVERD | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 18, 1983 | | | 2b. HOUR
8,26 PM | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 15 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
design cutter | |
| 12b. KIND OF BUSINESS OR INDUSTRY
clothing | | 13a. STREET ADDRESS
Clearview Village
16 Margaret Ave. Pasadena Md. | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur Baldwin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Nash | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213 28 1503 | | 17. INFORMANT
ADDRESS
Leonard Everd 16 Margaret Ave. 21122 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4960

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) pulmonary emphysema

DUE TO, OR AS A CONSEQUENCE OF

(c) coronary

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

chronic depression

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1983, to 10/18/83, that (I) (we) last
saw the deceased alive on about Oct. 1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James T. Bergevin, M.D. | | DEGREE | | 22c. DATE SIGNED
10/19/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CALVIN FUHRMANN M.D. | |
| 22e. ADDRESS
517 EMPIRE TOWERS | | 22f. ADDRESS
GLEN BURNIE, MARYLAND 21061 | | | | | |

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
10/21/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | 4001 Ritchie Hwy.
Baltimore Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR
OCT 21 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Gonce | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 7b. HOUR | | |
| I. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | OCTOBER 05, 1983 | | | 522 AM | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 20, 1907 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | | 13c. CITY OR TOWN
GlenBurnie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilhelm Kuester | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotte Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | |
| 17. INFORMANT
Husband | | | ADDRESS
Same as | | | 18. THEODOR FELLEISEN | | | 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Artherosclerotic Cardiovascular Disease</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 28, 1983</u> to <u>Oct. 5, 1983</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 4, 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Charles J. Wu</u> | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Oct. 5, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES J. WU, M.D. | | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 204
GLEN BURNIE, MARYLAND 21061 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Oct. 8, 83 | | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem Pk | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard MD | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, MD | | | 25a. DATE REC'D. BY REGISTRAR
OCT 6 1983 | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|--|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| | | | FIRST MIDDLE LAST
JOHN HAZZARD FISHER | | 10-7-83 | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| male | | | Caucasian | | 7-29-01 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Md. | | | USA | | 82 YRS. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Annapolis | | | Anne Arundel General Hospital | | Anne Arundel MD. | |
| 13a. STATE | | | 13b. COUNTY | | 13c. STREET ADDRESS | |
| MD. | | | A.A. | | 1100 MADISON ST. #B2 21408 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| John H. Fisher | | | Mary M. Winterly | | State of Md. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | 213-05-1879 | | Eleanor T. Fisher #13 same as | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>4292</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Cardio Vascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>chronic urinary tract infection</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | |
| | | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-25</u> 19 <u>83</u> to <u>10</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-25</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | |
| <u>W. Winterly</u> | | MD | | 10/7/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | |
| <u>WEINTRAUB</u> | | 104 FORBES St. Annapolis Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 10-11-83 | | Hillcrest | | Annapolis A.A. Md. |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | |
| Taylor Funeral Chapel | | Annapolis, Md. | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | 10/13/83 John J. Connel | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 2 5 7 1 0
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARJORIE P. P. FISHER | | 2a. DATE OF DEATH MONTH DAY YEAR
10 25 83 | | 2b. HOUR
3 05 A.M. | |
| 3. SEX
Female | 4. RACE
Caucasin | 5. DATE OF BIRTH MONTH DAY YEAR
1 10 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Arundel General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
A. Arundel | 13c. CITY OR TOWN
Crownsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George C. Parker | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Green | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
252-05-1310 | | 17. INFORMANT ADDRESS
Russell S. Fisher M.D. Lane 21032 | |

| | | | |
|---|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Heart Failure | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
M. TRAL VALVE Replacement | | | |
| 19a. DATE OF OPERATION
10/24/83 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary Artery Disease | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8 10 19 83 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24/83 to 10/25/83 , that (I) (we) last saw the deceased alive on 10/24/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
A. R. | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/25 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
10-25-83 | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MacNabb Funeral Home Catonsville, Md. | | 25a. DATE RECD. BY REGISTRAR
OCT 27 1983 | 25b. REGISTRAR'S SIGNATURE
John J. Laniel |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1864

1864

Handwritten text, mostly illegible due to fading and bleed-through. Some visible words include "March", "April", "May", "June", "July", "August", "September", "October", "November", "December".

1864

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 / 1 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edith C. Fogarty | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 - 24 - 83 | | 2b. HOUR
M |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 6, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Key punch operator | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | 13b. COUNTY
Camden | 13c. CITY OR TOWN
Pennsauken | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1711 Hollinsheard Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Wilcox | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Ann unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
ADDRESS
Maureen Schuler 687 Santa Maria Davidsonville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
1629 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Oat cell carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) 4 min
4 months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. acute ruptured diverticulum | | | | | |
| 19a. DATE OF OPERATION
10/12 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
above | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/10, 19 83, to 10/24, 19 83, that (I) (we) last saw the deceased alive on 10/24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stuart E. Selowick, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart E. Selowick, M.D. | | 22e. ADDRESS
51 Franklin St. Annapolis, Md 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
10/27/83 | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cem. | | 23d. LOCATION
CHURCH TOWN COUNTY STATE
Cherry Hill Camden, N.J. | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | 12. ADDRESS
12 Ridgely Ave.
Ann. Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

52-115-0

21

10

PAGE 1

RECEIVED
FBI
JAN 10 1964

RECEIVED FBI JAN 10 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 / 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Daniel F. Furth | | 2a. DATE OF DEATH MONTH DAY YEAR 10-2-83 | | 2b. HOUR 10:30 |
| 3. SEX M | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 4 83 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Anne Arundel Gen. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Anne | 13c. CITY OR TOWN Rose Haven | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel C. Furth | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Robin Garrett | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 888-20-3241 | | 17. INFORMANT ADDRESS Same as above |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BPD (Broncho Pulmonary Dysfunctional)
5191
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/12 , 19 83 , to 10/12 , 19 83 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE James W. Wheeler, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 10-3-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wheeler, M.D. | | 22e. ADDRESS Anne Arundel Gen. Hosp. Annapolis, Md. | | | |

| | | | |
|--|--------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 10-7-83 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 10 1983 | 25b. REGISTRAR'S SIGNATURE J. E. Carver |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

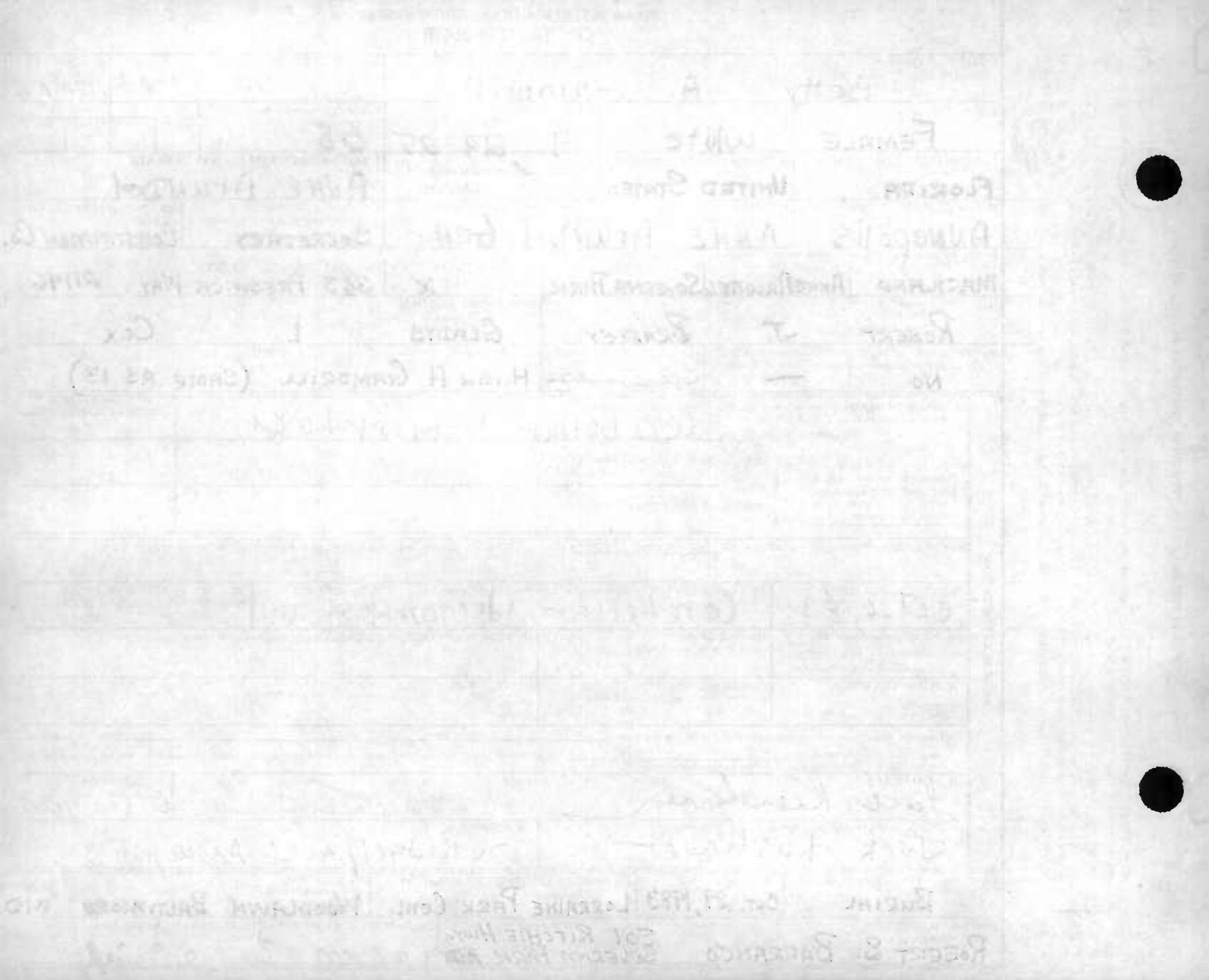
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Betty A. Gambrill | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 27 83 | | 2b. HOUR
1:22 P.M. |
| 3. SEX
FEMALE | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
9 24 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
FLORIDA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GEN. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION Co. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT J. BRADLEY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GLADYS L. Cox | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
261-30-8345 | | 17. INFORMANT
ADDRESS
HUGH H. GAMBRILL (SAME AS 13) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebellar Hemorrhage.
4310
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION
OCT 26, 83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cerebellar Hemorrhage | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jack Kushner | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
OCT 27, 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK KUSHNER | | | | 22e. ADDRESS
20 Ridgely Ave Annapolis | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
OCT. 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
LORRAINE PARK Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WOODLAWN BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | | | 501 RITCHIE Hwy.
SEVERNA PARK, MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert David Gantt | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 12 83 | | 2b. HOUR
7:35 AM | | | |
| 3. SEX
male | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 24 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Grocery Store | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | | | |
| 13a. STATE
MD | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
EDGEWATER | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1607 Old Towne Rd. 21037 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
577 05 1360A | | 17. INFORMANT
ADDRESS
2816 Carrollton Rd. Annapolis, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of STOMACH or PANCREAS
1519
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 Mo. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from OCT 02 , 19 82 , to OCT 12 , 19 83 , that (I) (we) last saw the deceased alive on 10/11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harvey J. Steinfield M.D. | | | | | | 22c. DATE SIGNED
10/12/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HARVEY J. STEINFELD | | | | | | 22e. ADDRESS
Annapolis, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | | | 23b. DATE
10/14/83 | | 23c. NAME OF CEMETERY OR CREMATORY
LAKEMONT | | 23d. LOCATION
CITY OR TOWN COUNTY
DAVIDSONVILLE AA, MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME
TAYLOR FUNERAL CHAPEL | | | | | | 25. DATE REC'D BY REGISTRAR
OCT 17 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | | | |

OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK

REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
ON JANUARY 10, 1900
RELATIVE TO THE
LANDS BELONGING TO THE STATE

ALBANY:
J.B. LIPPINCOTT & CO.
PRINTERS
1900

THE
LANDS BELONGING TO THE STATE
OF NEW YORK
IN 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| DANIEL | | GARCIA | | OCTOBER 29, 1983 | | 9:15 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | SPANISH | 11 4 12 | | 70 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| HAWAII | U.S.A. | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | | 13e. STREET ADDRESS / ZIP CODE | | | |
| MARYLAND | A.A. | SEVERNA PARK | | Heights 71 E. Earleights Road 21146 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| RAPHAEL GARCIA | | OPHAMEIA GARCIA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | Severna Park, Md. 211 FRANCES GARCIA 71 E. Earleigh Heights Rd. 46 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma right lung (T₂ N₂ M₀)</i>
1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 7-1-83 | | <i>Carcinoma right lung</i> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-17</i> 19 <i>83</i> , to <i>10-29</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>10-28</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | |
| <i>George S. Tan</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| GEORGE S. TAN, M.D. | | 4306 BELLE GROVE ROAD BALTIMORE, MD. 21225 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 11-1-83 | | HILL CREST CEMETERY | | Annapolis A.A. Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401 | | | | NOV 1 1983 | | <i>John J. Connel</i> | |



THE

NOV 11 1963

GARCIA

DANIEL

WIDE ARROW COUNTY

NORTH ARROW HOSPITAL

GLASS HURST

California

71 . and 72nd Sts

WATLAND A.A.

DAVID

FRANK

GARCIA

RAHMAN

THOMAS GARCIA

[Handwritten signature]

7-1-63

4306 BELLA GROVE ROAD

BALTIMORE, MD. 21225

GEORGE E. TAN, M.D.

WILLIAMS COUNTY, Maryland

11-1-63

LOUIS

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | EDT | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
WILBUR HENRY GARDE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 3, 1983 | | 2b. HOUR
950 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
2 11 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheet Metal | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severna Pk. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry Grade | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Reicher | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
214-03-2500 | | 17. INFORMANT ADDRESS
Lillian T. Garde 750 Oak Grove Circle 21146 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolus</u>
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic OBSTRUCTIVE PULMONARY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Congestive Heart Failure</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/03</u> 19 <u>83</u> , to <u>10/03</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/03</u> 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>E. Gorbaty MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/04/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELLIOTT GORBATY, M. D. | | | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 203
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/8/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk. AA Md. | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 5 - 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Garick</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James W GARDNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 12 83 | | 2b. HOUR
MIN.
10 55 P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
4 27 94 | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Boat Pilot | 12b. KIND OF BUSINESS OR INDUSTRY
Civil Service | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. CITY OR TOWN
EDGEWATER | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
21037 1212 CEDAR LANE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW1 213-18-6983 | | 17. INFORMANT
ADDRESS
Gardner Lowman - 1167 Carrswharf Rd
Mayo, MD 21106 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized atherosclerosis
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
concomitant metastatic melanoma | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (by me) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
G Mitchell | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10-12-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G Mitchell MD | | 22e. ADDRESS
205 Ridgely Ave Pknyol | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Oct. 17, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Mayo Memorial | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mayo A.A MD | 25b. REGISTRAR'S SIGNATURE
See e. e. e. e. | |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel - Annapolis, MD | | ADDRESS
OCT 18 1983 | | 25a. DATE REC'D. BY REGISTRAR | |

Handwritten notes at the top of the page, including the word "MIND" and various illegible scribbles.

Handwritten notes in the middle section, featuring the word "Yes" and other faint, illegible text.

Handwritten notes at the bottom of the page, including the word "Loving" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | EDT | |
|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) THOMAS ELSWORTH GINNEMAN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 16, 1983 | | 2b. HOUR
226 AM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
9 19 1999 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SERVICE REP. | | 12b. KIND OF BUSINESS OR INDUSTRY
AUTO REPAIR | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
238 GLENWOOD RD. (21122) | |
| 13a. STATE
MD. | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
PASADENA | 13e. STREET ADDRESS
238 GLENWOOD RD. (21122) | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS GINNEMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET APPLEBE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
215-03-7070 | | 17. INFORMANT
ADDRESS
ARNOLD, MD.
NORMA CONSTANT 106 MARINER CT. (21012) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Death due to
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Ventricular fibrillation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Possible Acute Myocardial Infarction
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Subarachnoid | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-15, 19 83 , to 10-16, 19 83 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
DALIT S. SAWNEY, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/16/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DALIT S. SAWNEY, M.D. | | | | 22e. ADDRESS
7422 BALTIMORE-ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
10/18/83 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A. MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
BALTO., MD. 21225
GEORGE J. GONCE F.H. 4001 RITCHIE HWY. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 19 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | |
|--|--------------|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES F. GOMOLJAK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-13-83 | | | 2b. HOUR
6:39 AM | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
1-26-06 | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Annapolis Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retail sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Bldg. supplies | |
| 13a. STATE
MD | | 13b. COUNTY
AAACs | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
346 Ridgely Ave 21401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Gomoljak | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | |
| 16b. SOCIAL SECURITY NO.
23-22-1019 | | 17. INFORMANT
Judy Bloom 640 Ridgely Ave. Ann. Md. | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Obstructive Pulmonary Disease

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from JAN 1, 19 83, to OCT 13, 19 83, that (I) (we) last saw the deceased alive on SEP 20, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE
BARRY R. NATHANSON | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY R. NATHANSON | | 22e. ADDRESS
51 Franklin St Annap, Md | | | | | |

| | | | |
|--|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
10/15/83 | 23c. NAME OF CEMETERY OR CREMATORY
St Marys Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Co. Md. |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | ADDRESS
12 Ridgely Ave.
Ann. Md. 21401 | |
| DATE REC'D. BY REGISTRAR
OCT 14 1983 | | REGISTRAR'S SIGNATURE
John J. Laniel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



100-1100-11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 3 2 5 7 2 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Floyd Abner Good</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>October 13, 1983</i> | | 2b. HOUR
<i>7:50 p.m.</i> |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12/14/1923</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>59</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel County</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Ferndale</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>5 Vista Avenue</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Machinist/ Kennecott Corp.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Anne Arundel</i> | 13c. CITY OR TOWN
<i>Ferndale</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Charles Francis Good, Sr.</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Hazel L. Allen</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>219-12-5266</i> | | 17. INFORMANT
ADDRESS
<i>Audrey M. Good Same as #13</i> | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Pancreas</i>
<i>1579</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>Feb 1983</i> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION
<i>2/11/83</i> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>C of Pancreas</i> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>4700 Pennington Ave., Balto., Md. 21226</i> | |
| 22a. I certify that (I) (the undersigned) deceased from <i>1983</i> to <i>Present</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Feb 22</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Colvin C. Carter M.D.</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<i>10/14/83</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dr. Colvin C. Carter, M.D.</i> | | 22e. ADDRESS
<i>4700 Pennington Ave., Balto., Md. 21226</i> | |

| | | | |
|---|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>10/17/1983</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Mem. Pk.</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Glen Burnie, A.A. Co., Md.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>McCully Funeral Homes</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 18 1983</i> | 25b. REGISTRAR'S SIGNATURE
<i>John J. Smith</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN M. GOSKIA | | | | | 2a. DATE OF DEATH
MONTH OCTOBER DAY 3 YEAR 1983 | | | | | 2b. HOUR
8 P M |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH FEB DAY 17 YEAR 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SEVERNA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
463 BALT. AND ANNAP. BLVD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GENERAL STORE | | 12b. KIND OF BUSINESS OR INDUSTRY
OWNER | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
463 BALTO. + ANNAP. BLVD 21146 | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | | | | | |
| 14. FATHER'S NAME
ANDREW SCHWARTZ | | | | | 15. MOTHER'S MAIDEN NAME
JULIA DONESKI | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-52-3370 | | 17. INFORMANT
ADDRESS
WALTER J. SOSNOWSKI (SAME AS 13) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
4100 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis
24hours
(c) DUE TO, OR AS A CONSEQUENCE OF A S C V D
30 years | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1983 to 9.30.83 , 19____, that (I) (we) lost saw the deceased alive on 9.30.83 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Paul Schonfeld</i> | | DEGREE
M.D. | | | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10.4.83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Schonfeld M.D. | | | | 22e. ADDRESS
407 CRAIN Highway Glen Burnie | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
OCT. 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEMETERY DUNDALK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | 501 RITCHIE HWY.
SEVERNA PARK, MD. | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | | | |

1982

1981

1980

1979

1978

1977

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1974

1973

1972

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1968

1967

1966

1965

1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 2 5 7 2 2
EST | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | 2b. HOUR |
| CHARLES EDWARD GOTT | | | OCTOBER 30, 1983 | | 0848 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Male | White | Dec. 31, 1938 | 44 YRS. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Office Worker | | Plumbing Co. |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS |
| Maryland | | | A, A, Co. | Pasadena, | 675 209th. St. Pasadena, Md. 21122 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| John GOTT | | | Eva Stallings | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 213-36-6730 | | Mrs. Laura R. Gott, Same as # 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>acute massive myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Defibrillation</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | DEGREE | | 22c. DATE SIGNED |
| JOSE M. PRESBITERO, M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 10/30/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | |
| JOSE M. PRESBITERO, M.D. | | | 7845 OAKWOOD ROAD, #107
GLEN BURNIE, MARYLAND 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | | Nov. 2, 1983 | Loudon Park Cemetery | | Baltimore, Maryland |
| 24. FUNERAL DIRECTOR | | | 25. DAY & REC'D. BY REGISTRAR | | |
| McCutty Funeral Home, Mt. & Ticken Rd. Pasadena, Md. 21122 | | | OCT 31 1983 John J. Conner | | |

100% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

| | | | | | | | | |
|--|--|--|---|--|-----------------------------------|---|--|--------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | OCTOBER 14, 1983 | | | 305 AM |
| ANNA D GRACIE | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | |
| Female | White | Oct. 5, 1929 | | 54 | | YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD. | U.S.A. | | | ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Housewife | | at home | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| MD. | | Anne Arundel | Pasadena | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 7728 Suitt Dr. 21122 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | |
| John P. Schultz | | Anne B. Aliff | | No N/A | | | | |
| 17. INFORMANT | | 18. SOCIAL SECURITY NO. | | 19. ADDRESS | | | | |
| Russell Gracie | | 212-28-2332 | | same as 13 e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Hepatic Failure | | | | | | | 1 month | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| (b) Metastatic oat cell carcinoma of lung | | | | | | | 1 yr. | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 9-23 | | 19-83 | | to 10-14, 19-83, that (I) (we) lost | | |
| saw the deceased alive on | | 10-13 | | 19-83 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| LONG S. HSU, M.D. | | M.D. | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE RECD. BY REGISTRAR | | | | |
| LONG S. HSU, M.D. | | 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061 | | OCT 18 1983 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | 10-17-83 | | Glen Haven Mem. Park | | Glen Burnie A.A. Md. | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. REGISTRAR'S SIGNATURE | | |
| Mc Cully Funeral Home | | 3204 Mountain Rd. | | 21122 | | John J. Smith | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

CHIEFLIN

20X CO ON EM



Serial 12-17-53 when shown on floor when found
with several other 3500 numbers at 21125

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|---|--------------|--|--|---|---|--|-------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FLOYD C. Green | | | 2a. DATE KNOWN OF DEATH
10 28 1983 | | | 2b. HOUR
8:50 P. M. | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
11-25-33 | 6. AGE (IN YEARS)
49 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
10 28 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
PRES. & MGR. REAL ESTATE | | 12b. KIND OF BUSINESS OR INDUSTRY
21146 |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
SEVERNA PK | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
308 FAIRTREE DR. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHESTER GREEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELEN ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
KOREAN 219306712 | | 17. INFORMANT
ADDRESS
CATHERINE E. GREEN - ABOVE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | | DATE SIGNED
10-29-83 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
11-1-83 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. VETERANS CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. MD | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Baranco | | ADDRESS
Severna Park, MD | | 25a. DATE REC'D. BY REGISTRAR
NOV 04 1983 | | 25b. REGISTRAR'S SIGNATURE
James J. Conner | | |

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.



QUILTON FIBER

END



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Nathan Greenberg | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10/23/83 | | | 2b. HOUR
10 ¹⁵ AM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 12 96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ROMANIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
REAL ESTATE OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
ANNE ARUNDEL | | | 13c. CITY OR TOWN
ANNAPOLIS | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEWIS GREENBERG | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PAULINE UNKNOWN | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | |
| 17. INFORMANT
MRS. ESTELLE GREENBERG | | | 18. SOCIAL SECURITY NO.
219-32-0492 | | | 19. ADDRESS
39 JEFFERSON PLA. ANNAPOLIS, MD 21401 | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular accident</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>brief</u> | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Obstructive Jaundice

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>10/17</u> , 19 <u>83</u> , to <u>10/23</u> , 19 <u>83</u> , that (I) <u>was</u> lost
saw the deceased alive on <u>10/23</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated
above, (I) <u>was</u> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>R. I. Hochman, MD</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10/24/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>R. I. Hochman, MD</u> | | 22e. ADDRESS
<u>16 Murray Ave. Annapolis, MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
OCT. 25, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
HAR SINAI | | 23d. LOCATION
OWINGS MILLS BALTO. MD | |

| | | | | | |
|---|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
OCT 27 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
|---|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| 1- STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|------------------------|--|--|--|---|--|--|--|---|--|---|--|--|--|----------------------|--|--|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert Lee Green | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 17 83 | | | | | | | | | | 2b. HOUR 1602 | |
| 3. SEX M | | 4. RACE Neg. | | 5. DATE OF BIRTH 8 14 35 | | 6. AGE (IN YEARS) 48 | | IF UNDER 1 YR. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS | | IF UNDER 24 HRS. <input type="checkbox"/> HOURS <input type="checkbox"/> MIN | | 2c. DATE PRONOUNCED DEAD 10 17 83 | | | | 2d. HOUR 1602 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. DC | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Crownsville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1255 Bacon Ridge Road | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY Fence Company | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY AA. | | 13c. CITY OR TOWN Crownsville | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS 1225 Waterbury Rd. | | | | | | | | | | | | | |
| 14. FATHER'S NAME Alexander | | | | 15. MOTHER'S MAIDEN NAME Carrie Tucker | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 577-44-7587 | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Hypertensive C.V.D.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY 19 HOUR AM MONTH 19 DAY 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, MD | | | | ADDRESS 695 America Ct, 21035 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/22/83 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George's MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. | | | | ADDRESS 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1983 | | | | 25b. REGISTRAR'S SIGNATURE John L. Smith | | | | | | | | | |



ROLLINS FUNERAL HOME, INC.
4332 HUNT PLACE, N.E.
WASHINGTON, D.C. 20019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1. FOR
STATE
REGISTRAR | | | | | 8 3 2 5 1 2 7
REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Kary Lyn Griffin | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 10 19 83 2b. HOUR 8:50 PM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 10 19 83 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS 6 6 | | IF UNDER 1 YEAR
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hos | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Calvert | | 13c. CITY OR TOWN
Lusby | | 13e. STREET ADDRESS
Old Mill Road 20657 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mark D Griffin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Karin J. Bowen | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mark D. Griffin address same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7400 An Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Anencephaly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hours. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | | | | | |
| 19a. DATE OF OPERATION
0 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
0 | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
P.A. | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Albert M. Gordon M.D. | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
10/17/83. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albert M. Gordon M.D. | | | | 22e. ADDRESS
20676 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/24/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Middleham Chapel Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lusby, Calvert, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Donald V. Borgwardt-Bx34-B-Port Republic, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 26 1983 | | 25b. REGISTRAR'S SIGNATURE
John E. Conrad | | | |

BP _____

James A. [unclear]

on [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

4.4

James A. [unclear]
James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE HAIG WILSON HAIG | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 3 83 | | 2b. HOUR
1 A M | | | |
| 3. SEX
M | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 14 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Edgewater | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
117 - River Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ELECTRICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
AACO | | 13c. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
117 RIVER RD. EDGE. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM SCHMIDT HAIG | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET VIRGINIA WILLIAMS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
045-01-7484-A | | 17. INFORMANT
ADDRESS
Margaret Chase (same as above) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEART FAILURE - ARYTHMIA
4149
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CVD.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 M.
- 15 yrs.
- 20 yrs. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CEREBROVASCULAR ACCIDENT. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
9-22 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
10 3 83 | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-22 , 19 81 , to 10 3 , 19 83 , that (I) (we) last saw the deceased alive on 9/27 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
LEMOND W. LOTT DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
10-3-83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEMOND W. LOTT | | | | 22e. ADDRESS
DAVIDSONVILLE MD.
21035 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10/5/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Geo. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. | | | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1983 | | 25b. REGISTRAR'S SIGNATURE
James J. Smith | | | |

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Wilson

Wilson

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY A. HAIG | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 15 83 | | 2b. HOUR
5:25 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
7 11 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTH PLACE (STATE OR FOREIGN)
Canada | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH
Edgewater | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pleasant Living Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse R.N. | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital |
| 13a. STATE
md. | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1005 Mastline Drive |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Peebles | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Laura Grover | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
366-24-9070 A | | 17. INFORMANT ADDRESS
John W. Haig 1005 Mastline Drive Annapolis, Maryland 21401 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1541

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Adenocarcinoma of rectum**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I (this hospital) attended the deceased from October 12, 1983 , to October 15, 1983 , that I (we) lost
saw the deceased alive on October 12, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. I (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
Jon B. Lowe | | DEGREE
MD | | 22c. DATE SIGNED
Oct. 15, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Jon B. Lowe, M. D. | | 22e. ADDRESS
77 West Street Annapolis, Maryland 21401 | | | |

| | | | |
|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Oct. 18, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis, Anne Arundel, MD |
| 24. FUNERAL HOME NAME
Beall Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
OCT 18 1983 | 25b. REGISTRAR'S SIGNATURE
John E. Carver |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|-----------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Edward Harris | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 10 24 83 | | 2b. HOUR 3 |
| 3. SEX
M | 4. RACE
NEG | 5. DATE OF BIRTH
MONTH 12 DAY 20 YEAR 16 | 6. AGE (IN YEARS)
LAST BIRTHDAY 66 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7d. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12 Johnson Place | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Md. | | 13b. COUNTY
AA | | 13c. STREET ADDRESS
12 Johnson Place | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE Harris LAST Harris | | 15. MOTHER'S MAIDEN NAME
FIRST Nancy MIDDLE Ann LAST Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
W.W.11 214-14-0017 | | 17. INFORMANT
ADDRESS Annapolis, Md. 316 F. Bestgate Rd. 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE William P. Jones, MD | | TITLE (SPECIFY) Deputy | | DATE SIGNED 10/24/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, MD | | ADDRESS 695 America Ct. 21035 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
10-27-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
HOPE U.M. CHURCH CEME. | |
| 23d. LOCATION
CITY OR TOWN
Edgewater, A.A. Maryland | | 23e. COUNTY
ANNE ARUNDEL | | | |
| 24. FUNERAL DIRECTOR
NAME WILLIAM REESE & SONS MORTUARY, P.A. | | 24a. DATE REC'D. BY REGISTRAR
OCT 25 1983 | | 24b. REGISTRAR'S SIGNATURE
John J. Calver | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
1. STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 83 25731 | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bernard Clifton HARRISON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Oct. 10, 1983 | | | | 2b. HOUR 4:00 A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 16, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Ann Arundel Co., MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
900 Coachway | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Rural carrier | | 12b. KIND OF BUSINESS OR INDUSTRY
Post Office | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Mt. Airy | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
802 North Main St. 21771 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Milton H. Harrison | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mollie Nusbaum | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. 1 | | 17. INFORMANT
E. June Harrison, | | ADDRESS
Item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 19 83 to 10 Oct 83 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 3 Oct 19 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John B. Lowe, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
11 Oct 83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John B. Lowe, M.D. | | | | 22e. ADDRESS
77 West St., Annapolis, Md. 21401 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
Oct. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mt. Airy, Carroll, Md. | | | |
| 24. FUNERAL DIRECTOR
Orin L. Molesworth, P.A., | | | | | | ADDRESS
Damascus, Md. | | 25a. DATE REC'D. BY REGISTRAR
OCT 14 1983 | | 25b. REGISTRAR'S SIGNATURE
James J. Connelley | |

BP

Oct. 1, 1913

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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2 5 7 3 2

REG. NO.

EDT

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| CLIFTON WILLIAM HARRYMAN | | | OCTOBER 14, 1983 | | | 354 AM _M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | Feb. 02, 1915 | 68 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | |
| Maryland | U.S.A. | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Machinist (Ret.) DuPont | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. INSIDE CITY LIMITS? | | | 13c. STREET ADDRESS | | |
| Maryland A.A. Glen Burnie | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 1673 Marley Avenue 21061 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Joshua Harryman | | | (Unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Yes | | | W.W. II 214-05-3844 | | | Mrs. Annabell F. Harryman (same as 13) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>4100</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Super Tension</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 3: (a) <u>Super Tension</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>20 days</u> |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10-12-83</u> to <u>10-14-83</u> that (1) (we) last saw the deceased alive on <u>10-12-83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | 22b. ADDRESS
375 HOSPITAL DRIVE, SUITE 208
GLEN BURNIE, MARYLAND 21061 | | | 22c. DATE SIGNED
10-15-83 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | | Oct. 17, 83 | | | Glen Haven Mem. PK Glen Burnie, A.A. MD | | |
| 24. FUNERAL DIRECTOR NAME
<u>Dean P. Charlton</u> | | | 25a. DATE REC'D. BY REGISTRAR
<u>OCT 18 1983</u> | | | 25b. SIGNATURE
<u>[Signature]</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS
Singleton Funeral Home Glen Burnie, MD | | | | | | | | |

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 83 25733 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| EDWARD C. HEINZ | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 4 83 | | | |
| 3. SEX Male | | | | 4. RACE White | | | |
| 5. DATE OF BIRTH Sept. 26, 1895 | | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 88 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor Nursing Home | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Packing | | | | 12b. KIND OF BUSINESS OR INDUSTRY Heinz Riverside Co. | | | |
| 13a. STATE Md. | | | | 13b. COUNTY A.A. | | | |
| 13c. CITY OR TOWN Pasadena | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS 7826 Harbor Road, 21122 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD HEINZ | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE TOEPFER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 215-09-0002 | | | |
| 17. INFORMANT ADDRESS Edna Spilman, (same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 25, 19 81, to OCT. 4, 19 83, that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED 10-4-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MICHAEL PEARLMAN | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Oct. 7, 1983 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 10 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | | | |

341

Enrico

WILLIAMS

10 4 83

W-09-0003

W-09

KATHLEEN

JOHN

W-09-0003

10 4 83

WILLIAMS

W-09

DR. WILLIAMS



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|-----------|--|--|--|--|---|--|-------------------------|--|--------------------------|--|-------|--|------|--|----------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| GORDON | | MICHAEL | | HEINZ | | | | 10-2-83 | | 19 | | | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | Caucasian | Sept. 18 1963 | | 20 YRS. | | | | | | 10-2-83 | | 19 | | | | | | 3:45A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | MD. | |
| Maryland | | US | | | | Anne Arundel County | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Glen Burnie | | Rt. 3 | | Student | | School | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | Prince Georges | | Bowie | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12902 Beaverdale Lane | | 20715 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| William F. Heinz | | Pauline H. Siira | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| no | | 213-84-7286 | | William F. Heinz | | same as 13e | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| 8147 | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 10-2-83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | pedestrian struck by an auto (s) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
hwy. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 3 Glen Burnie, Maryland | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | 22b. TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | DATE SIGNED 10-2-83 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn Street Balt., Maryland | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Oct. 4 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
First Lutheran Ch. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bowie, Maryland 20715 | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Beall Funeral Home | | ADDRESS
16000 Annapolis Road
Bowie, Maryland | | 25a. DATE REC'D. BY REGISTRAR
OCT 5 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
JAN 10 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



January 10, 1950

Mr. J. B. ...

Mr. J. B. ...

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. Thomas Smyth, M.D. Medical Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 2 5 / 3 5 | | | |
|---|--|--|--|---|--|---|--|
| FOR Item 13e phone
1- STATE REGISTRAR 10-2-83 cn | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Barbara ANN Hendricks | | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 24 83 | | 2b. HOUR
1:25P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 6 55 | | 6. AGE (IN YEARS LAST BIRTHDAY)
28 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH
Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
D.C. Children's Center Forest Haven | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | |
| 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | 13a. STATE
Md. | | 13b. COUNTY
A. A. CO. | | 13c. CITY OR TOWN
LAUREL | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT HENDRICKS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BETTY MOORE | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 17. INFORMANT
BARBARA ATKINS (FRIEND) | | 18. SOCIAL SECURITY NO
216-88-8023 | | 19. ADDRESS
SAME AS ITEM #13 | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE CARDIO-PULMONARY ARREST</u>
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>OCT 24</u> , 19 <u>83</u> , to <u>OCT 24</u> , 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>OCT 24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Rolando V. Goco, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
10-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rolando V. Goco, M.D. | | | | 22e. ADDRESS
3360 Center Lane
Laurel, Maryland 20707 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-27-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LANDOVER, P.G.C. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. W. CHAMBERS CO. 517 11th ST. S.E. WASH. D.C. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
OCT 28 1983 <u>John J. Conner</u> | | | |

BP

89-1550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 83 25136 | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
AUSTINE ARNETTA HENSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 28 83 | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
5 8 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
57 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A.A. GENERAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
md | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Sherman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Florence O'NEAL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
219-124108 | |
| 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral aneurysm
1809
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adenocarcinoma of breast with
(c) bone metastases.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Symptomatic, generalized calcareous, Decubiti ulcers | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
10-24 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (the hospital) attended the deceased from 10-27 85 to 10-28 83 , that (I) (two) last saw the deceased alive on 10-27 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE DEGREE
Errol A. Shilling MD | |
| 22c. DATE SIGNED
10-28-83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERROL A. SHILLING | | 22e. ADDRESS
200 Ridge Lane, Anne Md | | 22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
11-1-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Lawn mem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ANNAPOLIS A.A. md | |
| 24. FUNERAL DIRECTOR NAME
C.E. Hicks | | 24b. ADDRESS
1922 Forest Drive | | 24c. DATE REC'D. BY REGISTRAR
NOV 2 1983 | | 24d. REGISTRAR'S SIGNATURE
[Signature] | |

BP _____

APPROVED
DATE: 10/10/1971

VOLUNTARY

PC 100-2

A. A.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| ALBERT ROBERT HODGES, Sr. | | | | OCTOBER 29, 1983 | | | | 105 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | | White | | Dec. 25, 1910 | | 72 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Carpenter (ret) | | B.&O. Railrd. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | A.A. | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 107 Beach Road (21061) | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (son in law) ADDRESS | |
| Robert | | Mary | | Yes | | 218.05.7046 | | Frank L. Slavin, Jr. (same as 13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF | | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4850 | | Bilateral Basilar Pneumonia | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 22a. DATE OF OPERATION | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22c. AUTOPSY? | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| Pulmonary Fibrosis - RSD | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22e. I certify that (I) (this hospital) attended the deceased from 10/28/83 to 10/29/83, that (I) (we) last saw the deceased alive on 10/28/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | 22f. SIGNATURE | | 22g. DATE SIGNED | | | | | |
| | | Jorge B. Ramirez | | 10/29/83 | | | | | |
| 22h. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22i. ADDRESS | | 22j. DATE SIGNED | | | | | |
| RAMIREZ, JORGE B., M.D. | | 7845 OAKWOOD ROAD SUITE 205 GLEN BURNIE, MARYLAND 21061 | | 10/29/83 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. REGISTRAR'S SIGNATURE | |
| Burial | | Nov. 1, 1983 | | Glen Haven Mem. Pk. Glen Burnie A.A. MD | | CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | |
| | | Singleton Funeral Home | | Glen Burnie, MD | | NOV 1 1983 | | John J. Conner | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|-------------------------------------|---|---|--|------------------------|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR |
| MARGARET G. HORN | | | | | | OCTOBER 29, 1983 | | | 10:30P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | CAUCASIAN | | APRIL 24, 1899 | | 84 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | USA. | | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ANNAPOLIS | | ANNAPOLIS CONVALESCENT CENTER | | | | HOUSEWIFE | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS |
| PENNSYLVANIA | | | YORK | | YORK | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 175 SCARBORO DR. 17403 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| GEORGE | | | MAUDE | | HAEZLER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | |
| NO | | | 198-36-0145 | | TIEMANN N. HORN 500 FOREST HILL DR. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| 1629 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (b) <u>Carcinoma of Lung</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>36 Oct 83</u> to <u>29 Oct 83</u> , that (I) (we) last saw the deceased alive on <u>36 Oct 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| JON E. LOWE | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 31 Oct 83 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 23b. ADDRESS | | | |
| JON E. LOWE | | | | | | 77 WEST ST. ANNAPOLIS, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
(CITY OR TOWN COUNTY STATE) | | |
| BURIAL | | | 11-2-83 | | ARLINGTON NATIONAL CEM. | | ARLINGTON | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS | | | | | | NOV. 8 1983 | | | |

Handwritten: *Handwritten signature* 20.8.1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 11 per phone 10/19/83 dad 8. STATE OF MARYLAND | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| John A. Hornberger | | | | | Oct. 10, 1983 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| male | | | | | white | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| Oct. 25, 1900 | | | | | 82 | | | | |
| 7a. BIRTHPLACE (COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Baltimore, Md. | | | | | USA | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| | | | | | Anne Arundel MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| Annapolis | | | | | Annapolis Conv. Center | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bailiff | | | | | A.A.Co. Gov | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | | | |
| Md. | | | | | A.A. Co. | | | | |
| 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| Annapolis | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| John Adam Hornberger | | | | | Emma UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| yes | | | | | 1923-1946 218-26-1846 | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| Linda Shellem | | | | | 3028 Tarpon Dr Riva Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Lung Cancer | | | | | | | | | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/5 to 10/10, 1983, that (I) saw the deceased alive on 10/5, 1983, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | |
| R. I. Hochman, MD | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| R. I. Hochman, MD | | | | | | | | | |
| 22d. ADDRESS | | | | | | | | | |
| 16 Mcenvay Ave, Annapolis, Md | | | | | | | | | |
| 22e. DATE SIGNED | | | | | | | | | |
| 10/11/83 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| Burial | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 10/13, 1983 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| Cedar Bluff | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Annapolis Md. A.A.Co. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | |
| Hardesty Funeral Home | | | | | | | | | |
| ADDRESS | | | | | | | | | |
| 12 Ridgely Ave Ann. Md. 21401 | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| OCT 14 1983 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| John J. Carver | | | | | | | | | |

BP



100% COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|---|---|---|
| 1- FOR
STATE
REGISTRAR | | 25740 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | |
| CHARLES William HUESTED | | MONTH DAY YEAR
10 29 83 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) |
| MALE | W | MONTH DAY YEAR
1 15 1920 | 63 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| CONN. | USA | <input checked="" type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | ANNE ARUNDEL MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis | 260 B Hilltop LAWE | RET. U.S. ARMY | ARMY |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| MD. | AA | Annapolis | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 17. INFORMANT | |
| UNKNOWN | UNKNOWN | KATHERINE PENNINI | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16b. SOCIAL SECURITY NO. | 17. ADDRESS | |
| YES | 45-1966 | 122 Edgewater Pk.
BROOKLYN, N.Y. 10465 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) ASCVD. | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED | |
| | HOUR A.M. MONTH DAY YEAR
P.M. 19 | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION | |
| | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | |
| William P. Jones, MD. | | M.D. Registrar | |
| EXAMINER'S NAME (TYPE OR PRINT) | | MEDICAL EXAMINER | |
| William P. Jones | | ADDRESS | |
| | | POTOMAC MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION |
| BURIAL | 11/2/83 | ARLINGTON NAT'L | ARLINGTON Va. |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Taylor Funeral Chapel | NOV 02 1983 | | John J. Conner |



CHARTER William HUNTERED

June 11 1883

County of ... State of ...

George W. ...

10th ...

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Gardner - Arrest

ASDND

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12-11

FOR
- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25741

| | | | | | |
|--|-------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William GARETH Hughes | | | 7a. DATE KNOWN OF DEATH
ESTIMATED <input type="checkbox"/> Oct. 4 1983 | | 7b. HOUR
M 142R |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR Jan. 04 32 | 6. AGE (IN YEARS)
LAST BIRTHDAY 51 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR Oct. 4 1983 |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7e. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ticket Agent | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William G. Hughes | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Genevieve Cusick | | 12b. KIND OF BUSINESS OR INDUSTRY
Air Lines | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
277.28.8887 | | 17. INFORMANT
Mother ADDRESS
Same as Genevieve Hughes Kansas City | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD. w/ Cardiac Arrest
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
William P. Jones, MD | | TITLE (SPECIFY)
Deputy | | DATE SIGNED
4 Oct 83 | |
| EXAMINER'S NAME
(TYPE OR PRINT) William P. Jones, MD | | ADDRESS
695 America Ct. Davidsonville | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Oct. 8, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Riverside Cemetery | |
| 24. FUNERAL DIRECTOR
NAME H. B. Vinson | | 25a. DATE REC'D. BY REGISTRAR
OCT 6 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carroll | |
| 23d. LOCATION
CITY OR TOWN
Martins Ferry | | COUNTY
Ohio | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

William Carter High
No. 1
Mr. A. A. Carter
HARDY D. Carter

LIBER
X
William Carter
No. 1
Mr. A. A. Carter
HARDY D. Carter

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|---|--|
| 1. FOR
STATE
REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | October 12, 1983 | | | 3:00 P _M | | |
| 3. SEX
Female | | | 4. RACE
Oriental 0 | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Korea | | | Korea | | | Aug. 27, 1936 | | | 47 YRS. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Glen Burnie | | | 7983 Nol Park Ct. Apt. 301 | | | Maid | | | Motel | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | A.A. | | | Glen Burnie | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS / ZIP CODE | | | 21061 | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | 7983 Nol Park Ct. Apt. 301 | | | | | |
| Dong Gin Kim | | | Illmyung Kim | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | None | | | 217.90.5656 | | | Yun Ouk Hur (husband) same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Kidney</u>
<u>1890</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 Year</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>10/12/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| | | | | | | | | | Oct. 12, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Paul J. Chang, MD | | | 801 Crain Highway, S.E. Glen Burnie | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Cremation | | | Oct. 14, 83 | | | Security Process Inc. | | | Catonsville, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE RECD. BY REGISTRAR | | | 25b. SIGNATURE | | | | | |
| Singleton Funeral Home | | | OCT 18 1983 | | | Glen Burnie, MD | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Remains may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 25743

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Roy Methvin Hutchins Jr. | | | 2a. DATE OF DEATH
MONTH 10 DAY 16 YEAR 83 | | | 2b. HOUR
4:30 A M | | | | | | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH 11 DAY 24 YEAR 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Capt, USCG. | | 12b. KIND OF BUSINESS OR INDUSTRY
Military | | | | |
| 13a. STATE
MD | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
919 Melvin Road-21403 | | | |
| 14. FATHER'S NAME
FIRST Roy MIDDLE Methvin LAST Hutchins, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST Zuleta MIDDLE Ellis LAST Same as #13 | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO.
1941-1968 267-07-8689 | | 17. INFORMANT
Carolyn B. Hutchins | | | ADDRESS
#13 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1719

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to 10/16/83 , 19____, that (I) (we) last
saw the deceased alive on 10/15/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J.P. Watkins for Dr. E. Cole DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
10/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. P. WATKINS | | | | 22e. ADDRESS
121 Cathedral St, Annapolis MD | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | 23b. DATE
Oct. 17, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Burleigh G.P. MD | |
| 24. FUNERAL DIRECTOR
NAME Taylor Funeral Chapel-Annapolis, MD ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR OCT 19 1983 REGISTRAR'S SIGNATURE [Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 4 4

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Beverly Ann Hutchison | | | 2a. DATE OF DEATH
MONTH 10 DAY 4 YEAR 83 | | 2b. HOUR
925 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH Oct. DAY 8 YEAR 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 | IF UNDER 1 YEAR
MONTHS YRS. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNAPOLIS Convalescent Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
MD. | 13b. COUNTY
H.A. | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
105 MAGNOLIA LANE 21403 | |
| 14. FATHER'S NAME
FIRST MORRIS J. MIDDLE J. LAST MAYHEW | | 15. MOTHER'S MAIDEN NAME
FIRST MARY MIDDLE A.E. LAST COMO | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
LINDA EATON ADDRESS 3C Heritage Ct. ANNAPOLIS, MD. 21403 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ce luvy & CVS infection
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1977 , 19____, to 10/4/83 , 19____, that (I) (we) lost
saw the deceased alive on 10/3/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. Watkins | | DEGREE | | 22c. DATE SIGNED
10/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WATKINS | | 22e. ADDRESS
FRANKLIN ST. ANNAPOLIS MD 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
10/5/83 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION
CITY OR TOWN COUNTY
SUITLAND P.G. MD. |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel | | ADDRESS
ANNAPOLIS, MD. | | 25a. DATE REC'D. BY REGISTRAR
OCT 10 1983 | |

25b. REGISTRAR'S SIGNATURE
John J. [Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 4 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RAY (NMU) JEWELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-2-83 | | 2b. HOUR
18²⁰ HR | |
| 3. SEX
Male | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
9-23-1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A. A GEN. HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISPATCHER | | 12b. KIND OF BUSINESS OR INDUSTRY
UTILITY CO. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND A.A Co. ANNAPOLIS | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1401 POPLAR AVE 21401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH Jewell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha MOORES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE YEAR(S) DATES)
YES WWII | | 16b. SOCIAL SECURITY NO.
817-14-6984 | | 17. INFORMANT
ADDRESS
MARGARET ELLEN Jewell #13 Same as | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carotid-Duodenal Fistula
4414
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Massive G-I Hemorrhage
(c) Abdom. Aortic Aneurysm
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
72 Hr
72 Hr
Yrs. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Bleeding Diathesis | | | | | | |
| 19a. DATE OF OPERATION
10-2-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carotid-duodenal Fistula | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-30-83 to 10-2-83 , that (I) (we) lost
saw the deceased alive on 10-2-83 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not move the body after death. | | | | | | |
| 22b. SIGNATURE
GARY M. Richardson, M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10-2-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GARY M. Richardson | | 22e. ADDRESS
107 Forbes Street Annapolis-MD 21401 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-5-83 | | 23c. NAME OF CEMETERY OR CREMATORY
MD Vet. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville AA MD |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel | | ADDRESS
ANNAPOLIS MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 4 1983 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

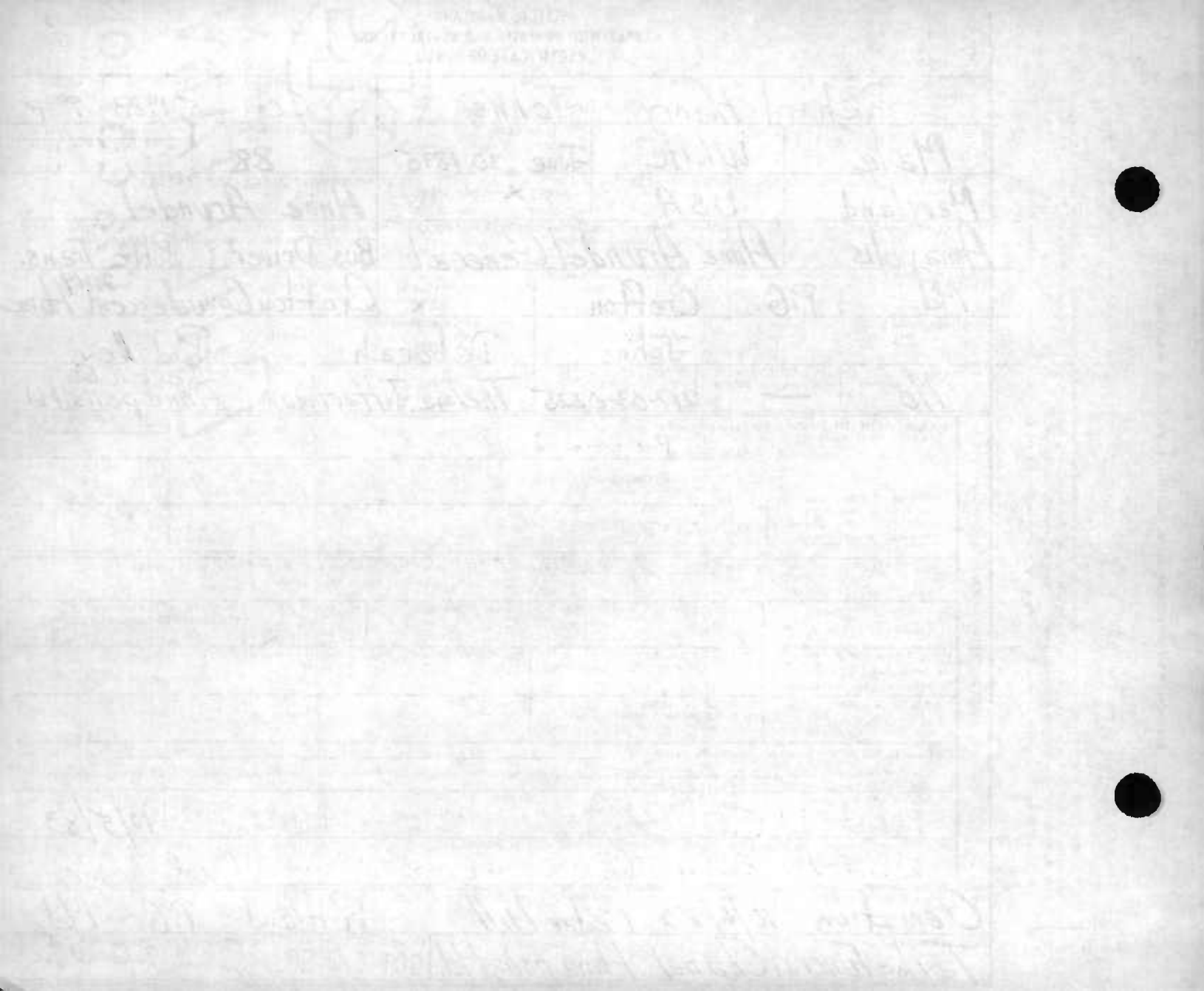
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Henry Johns | | | | 2a. DATE OF DEATH - MONTH DAY YEAR Oct. 5, 1983 | | | |
| 3. SEX Male | | | | 4. RACE White | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR June 30 1895 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | | |
| 7a. BIRTHPLACE - (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10a. CITY OR TOWN OF DEATH Annapolis | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Anne Arundel General | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver | | | | 12b. KIND OF BUSINESS OR INDUSTRY Public Trans. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 1335 5th St. Md. | | | | 13b. CITY OR TOWN 116 A.A. Crofton | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Johns | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Bidgley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 212-03-0225 | | | |
| 17. INFORMANT ADDRESS Thelma J. Hartman 5 Revel St. Annapolis, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert M. Greenfield DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Greenfield, M.D. | | | | 22e. ADDRESS 139 Old Solomon's Isl Rd. Annapolis Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 10/6/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Swirland P.G. Md. | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel ADDRESS Annapolis Md. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 10 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
William Philip Johnston | | | | 2b. HOUR
1108AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 3, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 10 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Arnold | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
447 Century Vista | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Broker & Acct. Ins. Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Arnold | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 447 Century Vista 21012 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Johnston | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Agnes Pellitier | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
11942-1945-014-101264 | | 17. INFORMANT NAME ADDRESS
Harriet E. Johnston Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4029
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Dis 6 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
CARCINOMA OF COLON STATUS POSTOP. CVA; POST STATUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 8-24-78 to 10-7-83, that (1) (we) lost saw the deceased alive on 9-25-83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward S. Beck M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
10/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward S. Beck, M.D. | | | | 22e. ADDRESS
Forest Drive, Annapolis, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Oct. 11, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville A.A. MD | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel - Annapolis | | | | 25a. DATE REC'D. BY REGISTRAR 13 1983 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |

Washington, D.C.
January 11, 1901
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed amendment to the act of March 3, 1879, relating to the collection of duties on foreign goods.

The Department has no objection to the proposed amendment, and it is recommended that it be passed by the House of Representatives. Very respectfully,
Your obedient servant,
J. B. Thompson, Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 3 2 5 / 4 8 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| A/K/A Dorothy V JONES | | | | 10-23-83 7:30 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| FEMALE | | CAUCASIAN | | 2 17 20 | | 63 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| West Virginia | | USA | | | | Anne Arundel MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | Anne Arundel General Hospital | | Manager | | Food Service | |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | |
| MD | | AA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 312 Cedar Lane 21403 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| Alexander Williams | | Eliza Hawkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| NO | | 232-48-5347 | | William Griffey Jones | | 1706 Crownsville Rd
Annapolis, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast with
1749 metastases.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) 3 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19 1983, to 10/23 1983, that (I) (we) last saw the deceased alive on 10/23 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Gregory A. Mitchell MD | | DEGREE | | 22c. DATE SIGNED
10/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| Gregory A. Mitchell, MD | | 205 Ridgely Ave, Annapolis, MD 21404 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | Oct 27, 1983 | | Alex Williams | | Cowen Webster, KYA | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25. DATE RECEIVED BY REGISTRAR | | 25. REGISTRAR'S SIGNATURE | |
| Taylor Funeral Chapel - Annapolis, MD | | | | OCT 26 1983 | | | |

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Handwritten notes on lined paper, including dates like 1928 and 1929, and various illegible entries.

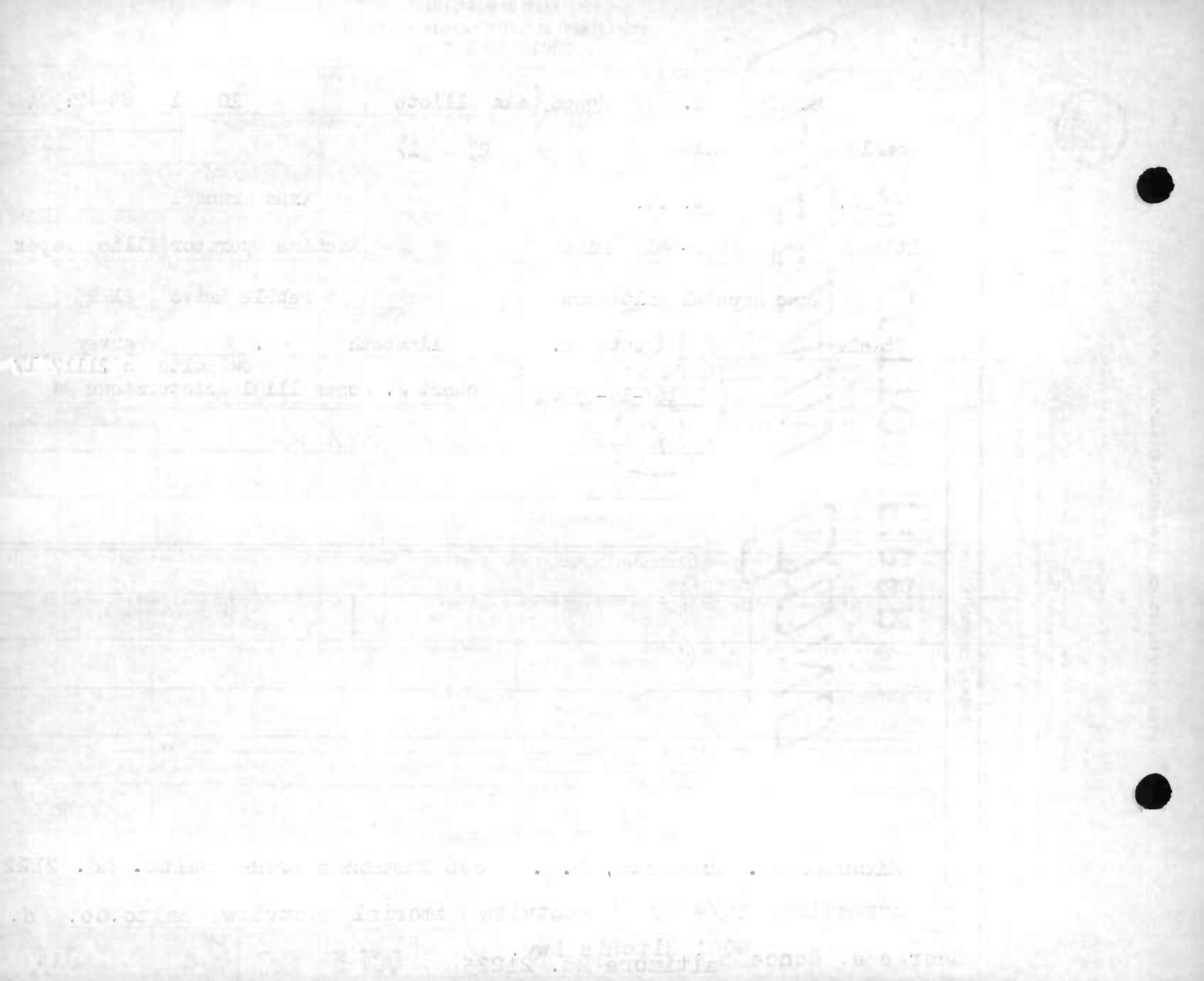
1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Hazel H. Jones (aka Elliott) | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 1 83 | | | 2b. HOUR
7:30A M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | | | | |
| 10. CITY OR TOWN OF DEATH
Brooklyn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
#8 Pebble Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machine Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Allied Paper | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
#8 Pebble Drive 21225 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley Lentz Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth M. Harvey | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
165-14-9548A | | 17. INFORMANT
ADDRESS
Cwings Mills, Md 21117
Robert J. Jones 11131 Reisterstown Rd | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Myocardial Coronary Vessel Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Atrial Fibrillation</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Michael H. Schwartz</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
10/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael H. Schwartz, M.D. | | | 22e. ADDRESS
606 Hammonds Lane Balto. Md. 21225 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
cremation | | | 23b. DATE
10/4/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westview Balto.Co. Md. | | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy.
Baltimore Md. 21225 | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 5 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25750

1. FOR
STATE
REGISTRAR

Martha.

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MARTHA KATHRYN JUSTICE

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

Oct. 22. 1983 10:56 PM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

Aug. 18 1909

6. AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Corinth, Miss.

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

MD.

10. CITY OR TOWN OF DEATH

Crownsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Box 348 Hall Rd.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE) Shirt Presser

12b. KIND OF BUSINESS OR INDUSTRY

Laundry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Pa.

13b. COUNTY

Bedford

13c. CITY OR TOWN

Clearville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Rt 3 Box 222 99999 15535

14. FATHER'S NAME

Unknown

MIDDLE

Pittsinger

15. MOTHER'S MAIDEN NAME

Emma

MIDDLE

STORK

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

212-36-9443

ADDRESS

Martha Bunner Rt 3 Box 222 Clearville Pa. 15535

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

1889 IMMEDIATE CAUSE (a) Transferred cell C Bladder

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

none

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORKNOT WHILE ☐ AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from Oct 18 1983 to Oct 22 1983, that (1) (we) lost saw the deceased alive on 10/4/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE

David S. McHold M.D.

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

10/24/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DAVID S. MCHOLD

22e. ADDRESS

16 MURRAY AVE, ANNAP

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Cremation

23b. DATE

Oct. 24, 1983

23c. NAME OF CEMETERY OR CREMATORY

Westview PK.

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

md.

STATE

24. FUNERAL DIRECTOR

NAME

T. A. Hardesty

ADDRESS

Annapolis md 21401

25a. DATE REC'D BY REGISTRAR

OCT 24 1983

REGISTRAR'S SIGNATURE

John J. Carver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Laura Rhodes Kaiser | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Oct. 18, 1983 | | | 2b. HOUR
M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 15, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Annapolis Nursing Conv. Cen | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
household | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Rhodes | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Virginia Dorsey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
212-74-8728 | | 17. INFORMANT
ADDRESS
Yolanda Stender Arnold Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u>
4379
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>Several years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>82</u> , to <u>10/18</u> , 19 <u>83</u> , that (I) <u>have</u> lost saw the deceased alive on <u>10/12</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was not</u> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>R. Hochman, M.D.</u> | | | | | | 22c. DATE SIGNED
10-18-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard I. Hochman, M.D. | | | | | | 22e. ADDRESS
16 Murray Avenue, Annapolis, MD. 21401 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Christ Episcopal Church | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
West River, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home 12 Ridgely Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 19 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Smith</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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| #5 per call w/F.H. 11/2/83 kam | | | | STATE OF MARYLAND | | 8 3 | | 2 5 / 5 2 | |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | |
| CERTIFICATE OF DEATH | | | | REG. NO. | | EDT | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JUDSON CHARLES KEENER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 26, 1983 | | 2b. HOUR
630 AM | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-4-1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maint. Mech. | | 12b. KIND OF BUSINESS OR INDUSTRY
Saga Foods | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Severn, Md | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
740 Old Donaldson Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fred - Keener | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Esther - Vanderpool | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
165-16-1870 | | 17. INFORMANT ADDRESS
Gladys Keener 740 Old Donaldson Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4149
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
CORONARY ARTERY DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/26/83 to Same 19____, that (1) (we) lost saw the deceased alive on never 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
Richard A. Marasa M.D. | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/26/83 | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD A. MARASA, M. D. | | | | 22e. ADDRESS
301 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10-29-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Crest Lawn Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard County, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Raymond C. Fink Glen Burnie, Md | | | | 25a. DATE REC'D. BY REGISTRAR
10/26/1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

| | |
|----------------|----------------|
| DATE | 10-10-50 |
| TO | SA [illegible] |
| FROM | SA [illegible] |
| SUBJECT | [illegible] |
| RE | [illegible] |
| INFO | [illegible] |
| ADVIS | [illegible] |
| NOTES | [illegible] |
| ADMINISTRATIVE | [illegible] |
| OTHER | [illegible] |

CONFIDENTIAL

| | |
|----|-------------|
| 1 | [illegible] |
| 2 | [illegible] |
| 3 | [illegible] |
| 4 | [illegible] |
| 5 | [illegible] |
| 6 | [illegible] |
| 7 | [illegible] |
| 8 | [illegible] |
| 9 | [illegible] |
| 10 | [illegible] |

| | |
|----|-------------|
| 11 | [illegible] |
| 12 | [illegible] |
| 13 | [illegible] |
| 14 | [illegible] |
| 15 | [illegible] |
| 16 | [illegible] |
| 17 | [illegible] |
| 18 | [illegible] |
| 19 | [illegible] |
| 20 | [illegible] |

20% COTTON F



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 3 3 2 5 / 5 3 | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | EDT | |
| 1. DECEASED NAME
(TYPE OR PRINT) BARRY CLINTON KEIPER | | | | | | 2a. DATE OF DEATH
MONTH OCTOBER DAY 16 , YEAR 1983 | | 2b. HOUR
920 PM | | M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH NOV DAY 5 , YEAR 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 | | IF UNDER 1 YEAR
MONTHS YRS. DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Sears Inc | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
GlenBurnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
136 Carroll Road 21061 | |
| 14. FATHER'S NAME
FIRST Herbert MIDDLE Clinton LAST Keiper | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Augusta MIDDLE Ahaus LAST Ahaus | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
1957-1961 216.34.352 | | 17. INFORMANT
Sister Mary L. Rao | | ADDRESS Winchester, PA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left Intracerebral Haemorrhage
4310
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Crisis
DUE TO, OR AS A CONSEQUENCE OF.
(c) App. 12 hours | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET — CITY OR TOWN — COUNTY — STATE — | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/16/83 to 10/16/83 , that (I) (we) last saw the deceased alive on 10/16/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. Pathmanathan MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. PATHMANATHAN, M.D. | | | | | | 22e. ADDRESS
325 HOSPITAL DRIVE, SUITE 108
GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Oct. 19, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem Pk | | 23d. LOCATION
CITY OR TOWN Elkridge COUNTY Howard STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME AB Viewers
Singleton Funeral Home, Glen Burnie, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 18 1983 | | 25b. REGISTRAR SIGNATURE
John J. Smith | | | |

BP

20% COTTON FIBRE

CHIEFTAIN



MADE IN U.S.A. 100% COTTON FIBRE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Adele Keldie | | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 - 2 - 83 | | | |
| 3. SEX
FEMALE | | 4. RACE
Caucas. | | 5. DATE OF BIRTH MONTH DAY YEAR
1 29 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
97 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Crownsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FAIRFIELD N. HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY
Ret | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE
MD. | | 13b. COUNTY
ADA Co. | | 13c. CITY OR TOWN
Annapolis | | 13e. STREET ADDRESS
296 HAWSEY RD. 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
STEPHEN D. BARTOW SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ALICE WINTERMUTE | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16a. SOCIAL SECURITY NO.
139 266379 | | 17. INFORMANT ADDRESS
JAUNET K. BOATMAN #13 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary vascular congestion
DUE TO, OR AS A CONSEQUENCE OF (c) 2866
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
mental deterioration - old age | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
Present | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 9-11 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE
Peter F. VerKouwen MD. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10-3-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. VERKOUW | | | | 22e. ADDRESS
1419 FOREST DR. ANNAPOLIS, MD, 21403 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
10/3/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BRENTWOOD P.G. MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Taylor Funeral Chapel Annapolis | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
OCT 4 1983 [Signature] | | | |

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WASHINGTON, D.C. 20250

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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---------|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| John William Kemmer, Jr. | | | | October 15, 1983 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | White | 2- 27- 1936 | | 47 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | | | Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Pasadena | | 1218 Hill Creek Rd. 21122 | | Dispatcher | | Shipping Co. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md. | | Baltimore | | Middle River | | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| John William Kemmer, Jr. | | Louise Smith | | Yes | | 219-32-3696 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1991 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Lyna Kemmer same as 13 e | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25/83, to 9/23, 1983, that (I) (we) last saw the deceased alive on 9/23, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| MARVIN J. FELDMAN | | MD | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| | | 302 Greenspring Station, Baltimore, Md. | | Burial | | 10-19-83 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Md. Vets. Cent. | | Crownsville, Md. | | Mc Cully Funeral Home 3204 Mountain Rd. 21122 | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | John J. Givens | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. For use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | EDT | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
AVIOUS CORA KESS | | | | MONTH DAY YEAR
OCTOBER 20, 1983 | | 7:35 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Black | | MONTH DAY YEAR
1 25 1912 | | 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| A A Co. Md. | | U. S. A. | | | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Homemaker | | At. Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. A A Glen Burnie | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7900 Benesch Circle Apt. 75 H 21061 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)
Nathaniel KESS | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Queenie V. Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT ADDRESS
Ilean Pinkett Pasadena, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4148 IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19/83 to 10/20/83, that (I) (we) last saw the deceased alive on 10/19/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Recep Erol | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RECEP EROL, M.D. | | | | 22e. ADDRESS
325 HOSPITAL DRIVE
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
10/25/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion Church, Pasadena, Md | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Pasadena, Md | | | | 23e. DATE REC'D. BY REGISTRAR
OCT 24 1983 | | 23f. REGISTRAR'S SIGNATURE
John J. Carver | |

BP

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7:35:10 OCTOBER 20, 1951

WASH

AREA

AVIATION

ANNE ARUNDEL COUNTY

GLYN BURNIE NORTH ARUNDEL HOSPITAL

355 HOSPITAL DRIVE

355 HOSPITAL DRIVE
GLYN BURNIE, MARYLAND 21061



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORA MARCELLA KILLIAN | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 3, 1983 | | | 2b. HOUR
1:20 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 29, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Linthicum | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21090
709 Edgewood Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown McDonnell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Son
Edward D. Killian | | ADDRESS
Same as
13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular</i>
4292 DUE TO, OR AS A CONSEQUENCE OF <i>Disease</i>
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a:
<i>Arterial fibrillation with large Bundle Branch Block.</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Jose M. Presbitero, M.D.</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSE M. PRESBITERO, M.D. | | | | 22e. ADDRESS
7845 OAKWOOD ROAD, #107
GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Oct 6, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Johns Evan. Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pittston PA | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>John J. Gurnick</i> | | | | ADDRESS
Singleton Funeral Home, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 4 1983 | | REGISTRAR'S SIGNATURE
<i>John J. Gurnick</i> | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

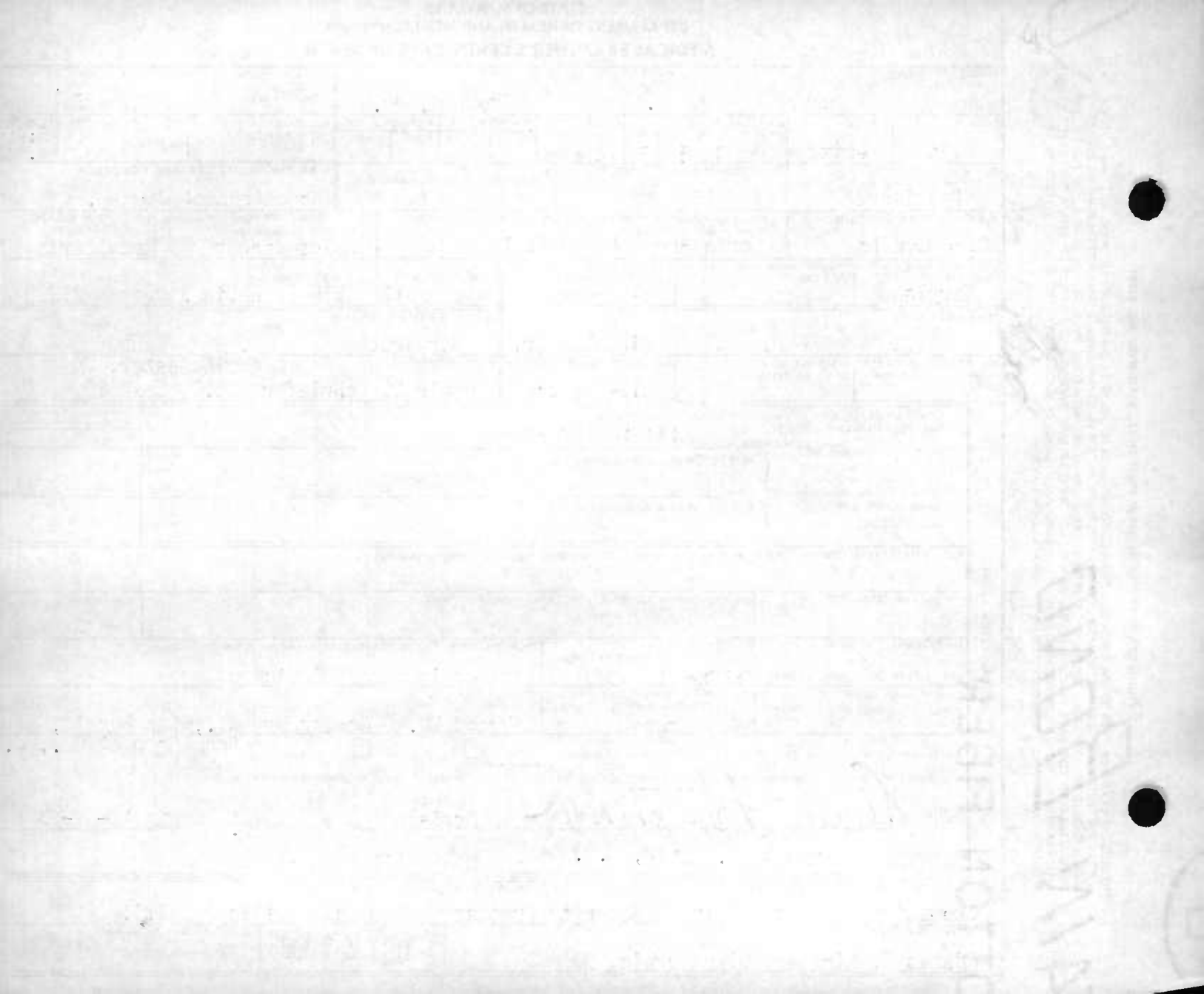
BP _____
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(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|------------------|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
August H. Kirschke, Jr. | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
10 29 1983 | | | 2b. HOUR
5:45 a. m. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 1, 1936 | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
10 29 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesmanager | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Parts |
| 13a. STATE
Maryland | | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
August H. Kirschke, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret M. Hauf | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
219-32-5270 | | 17. INFORMANT
ADDRESS
Winchester, VA
Angela E. Schriefer, Rt. 5, Box 510, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8120 IMMEDIATE CAUSE (a) Multiple Injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:19xx 10 29 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver in auto/auto impact | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Oakwood Rd. & Canterbury Ct., Glen Burnie, Anne Arundel Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY):
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
10-29-83 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Oct. 31, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balti. MD | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley, Glen Burnie, MD | | | | 25a. DATE REC'D BY REGISTRAR
OCT 31 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Lohr</i> | |

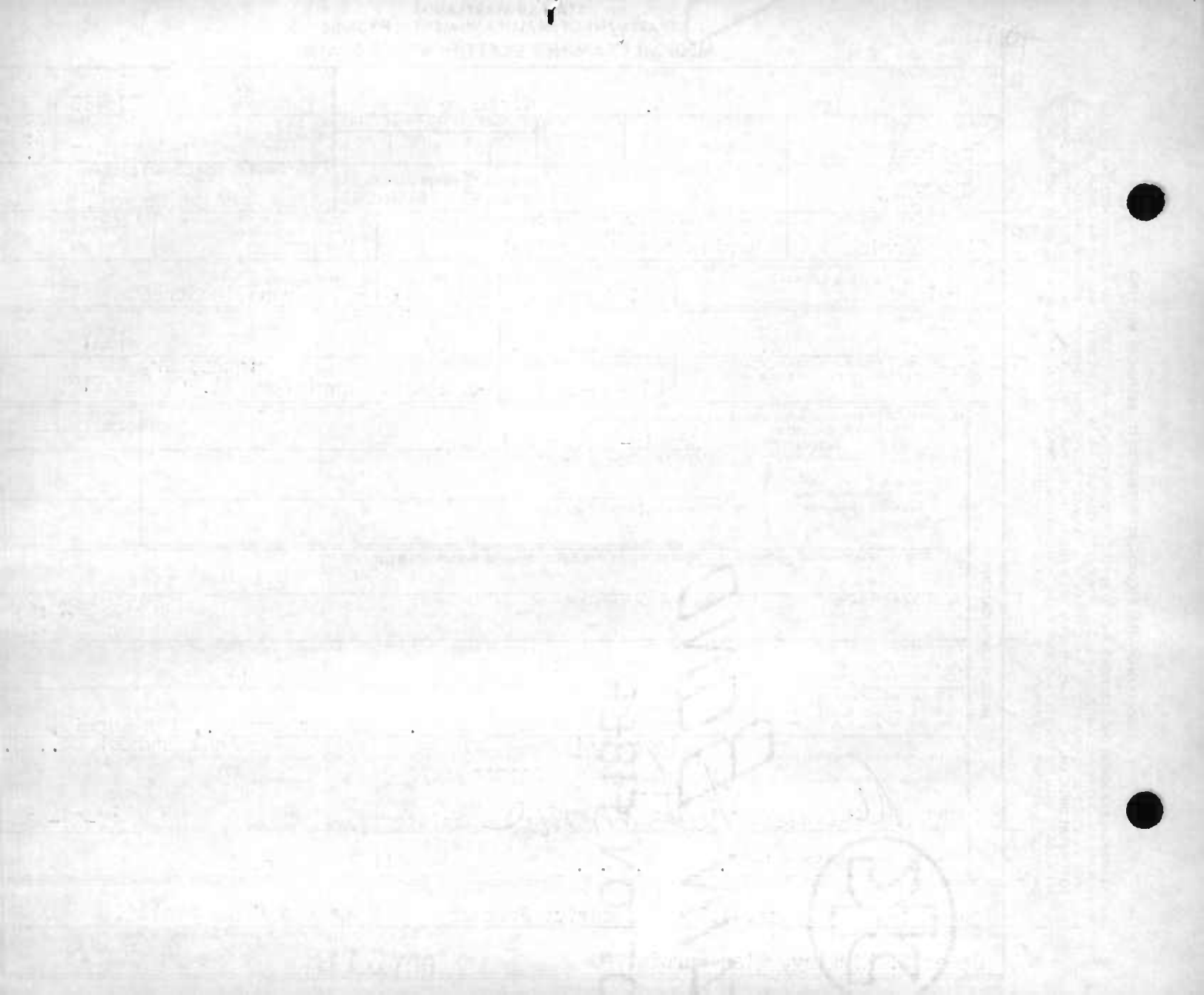


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|------------------|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ivy C. Kirschke | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
10 29 1983 | | | 2b. HOUR
M
3:25 a. M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 7, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
10 29 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert R. Radtke, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ivy Diehl | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-30-6867 | | | | 17. INFORMANT
Winchester, VA
Angela E. Schriefer, Rt. 5, Box 510, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8121 IMMEDIATE CAUSE (a) Cranio-cerebral Injury
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:19 PM 10 29 1983 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
passenger in auto/auto impact | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Oakwood Rd. & Canterbury Ct., Glen Burnie, Anne Arundel Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
10-29-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
Oct. 31, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balti. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
James S. Kirkley, Glen Burnie, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 6 0

1 - STATE
REGISTRAR

REG. NO.

EDT

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WALTER John KOCHANSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 29 1983 | | | 2b. HOUR
630 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 26, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Merchant Marine | |
| | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Exxon | |

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13e. STREET ADDRESS
(21061)
106 Georgia Avenue N.E. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Kochanski | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lina Bizezinski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W. II 215.10.0067 | | 17. INFORMANT
Jane T. Nicklas (daughter) Severn, MD | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4860

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cerebrovascular Disease

| | | | | | | | |
|------------------------|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|---|--|---|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 10-17, 1983, to 10-29, 1983, that (I) (we) lost
 saw the deceased alive on 10-29, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated
 above (I) (we) did (did not) view the body after death.

| | | | | | |
|--|--|--|--|------------------------------|--|
| 22b. SIGNATURE
Edward N. Sherman | | DEGREE | | 22c. DATE SIGNED
10-29-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD N. SHERMAN, M.D. | | 22e. ADDRESS
7422 BALTIMORE ANNAPOLIS BOULEVAR
GLEN BURNIE, MARYLAND 21061 | | | |

| | | | | | | | |
|--|--|------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Nov-2, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk Balto., MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Singleton Funeral Home Glen Burnie, MD | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 1 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lauer | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: SAC, [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

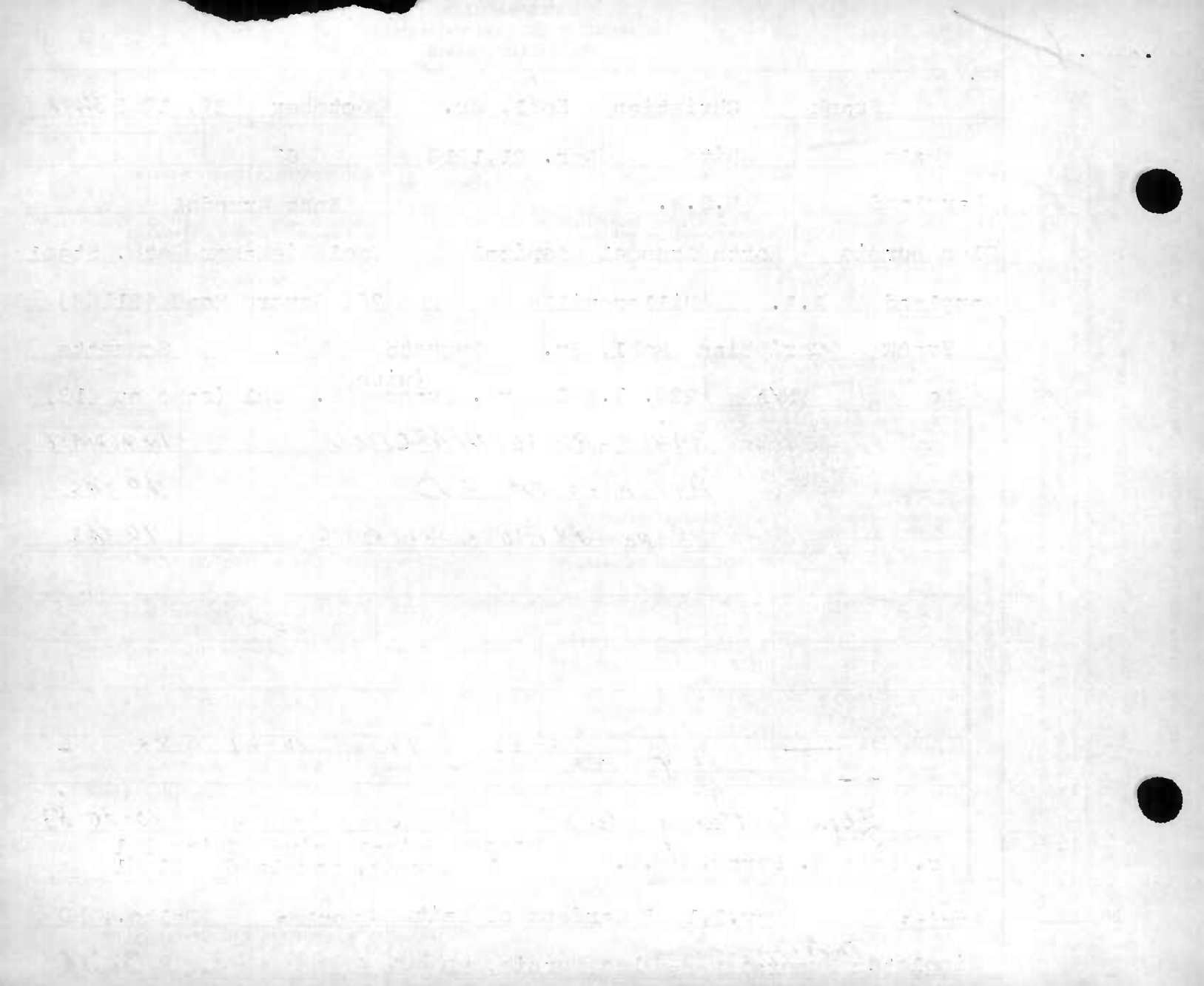
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 83 25761 | |
|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank Christian Kohl, Jr. | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 29, 1983 | | 2b. HOUR
3:47 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Apr. 21, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tool & Die Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Millersville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
262 Severn Road (21108) |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Christian Kohl, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Augusta D. Schuette | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT (wife)
Mrs. Frances E. Kohl (same as #13) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>M40 CARDIAL INFARCTION</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HYPERTENSIVE C.V.D.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CORONARY ATHEROSCLEROSIS</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u>
<u>10 YRS.</u>
<u>10 YRS.</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-22</u> , 19 <u>74</u> , to <u>10-29</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10-4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Leon C. Perry, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10-30-83</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Leon C. Perry, M.D. | | 22e. ADDRESS
325 Hospital Drive Suite 201
Glen Burnie, Maryland 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Nov. 2, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Overlea Balto., MD |
| 24. FUNERAL DIRECTOR
NAME
<u>R. H. Hopkin</u> | | ADDRESS
Singleton Funeral Home Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR
NOV 1 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Canfield</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|---------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph Hammond Lacy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Oct. 11 1983 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
12-18-1911 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Roanoke Va. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundle Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
Churchton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5608 Exeter St. Franklin Manor | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Gov. | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Churchton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
5608 Exeter St 20733 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Gold Lacy | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF NOT KNOWN, GIVE WAR OR DATES)
NONE | 17. INFORMANT
ADDRESS
Howard Lacy Annapolis Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest - unexpected.
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Parkinson's Disease - severe. | | | | | |
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 29 , 19 81 , to Sept 26 , 19 83 , that (I) (we) last saw the deceased alive on Sept. 26 , 19 83 , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <u>not</u> view the body after death. | | | | | |
| 22b. SIGNATURE
W. B. Freedberg | | DEGREE
MD | | 22c. DATE SIGNED
10/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. Freedberg | | 22e. ADDRESS
Owensville Med Center 20778
134 Owensville Road, West River | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
10-14-83 | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Davidsonville, Md. | |
| 24. FUNERAL DIRECTOR
Hardesty Funeral Home Annapolis Md. | | | 25a. DATE REC'D. BY REGISTRAR
OCT 14 1983 | | |

REGISTRAR'S SIGNATURE
John J. Lister



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 5 / 6 3

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
BEATRICE B. LAW | | | 2a. DATE OF DEATH MONTH DAY YEAR
10-29-83 | | | 2b. HOUR
A_M | |
| 3. SEX
FEMALE | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
10 26 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | |
| 7a. BIRTHPLACE (COUNTRY)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
EDGEWATER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
59 SHAMA RD. | | 12a. USUAL OCCUPATION
(IF WORKING AT TIME OF DEATH)
Professor Education | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
EDGEWATER | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALBERT BRENNEMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
BEATRICE WOODLING | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
14300 CHANT FOX LAKE | |
| 17. INFORMANT
ROBERT LAW | | 17. ADDRESS
BOWIE, MD. 20715 | | 17. ADDRESS | | 17. ADDRESS | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden cardiac death (in sleep)
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
Severe generalized Atherosclerosis
Cardiovascular disease. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant.
Years. | |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10-11 , 19 83 , to 10-17 , 19 83 , that (I) (we) lost
saw the deceased alive on 10-17-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Peter F. Verkouw MD | | | | DEGREE | | 22c. DATE SIGNED
10/29/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. VERKOUW MD | | | | 22e. ADDRESS
1419 FOREST Dr. Annapolis, Md. 21403 | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
CREMATION | | 23b. DATE
10/31/83 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SOUTHAWD P.G. MD. | |
| 24. FUNERAL DIRECTOR
NAME
TAYLOR FUNERAL CHAPEL | | | | ADDRESS
Annapolis Md. | | 25a. DATE REC'D. BY REGISTRAR
NOV 02 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | EDT | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EMMA ELIZABETH LILLY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 28, 1983 | | 2b. HOUR
12:25 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 7, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Meat Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A.A.Co. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carroll ----- Lodwick | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edna ----- Phillips | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
289-18-2843 | |
| 17. INFORMANT
ADDRESS
Mr. James C. Lilly, Same as above | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Electrolytic Anoxia
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Cardiogenic Shock
(c) Double myocardial infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 AM
Days
Days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-28-83 to 10-28-83 , that (I) (we) last saw the deceased alive on 10-28-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Hilary T. O'Herlihy | | | | DEGREE
M.D. | | 22c. DATE SIGNED
10-29-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HILARY T. O'HERLIHY, M.D. | | | | 22e. ADDRESS
325 HOSPITAL DRIVE #208
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Nov. 1, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCutty Funeral Home, 237 E. Patapsco Ave. Balto. Md. 21225 | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

BP

EDT

OCTOBER 24, 1963 12:52

ELIZABETH

ELIZABETH

ELIZABETH

ANNE ARUNDEL COUNTY

NORTH ROUNDEL HOSPITAL

OPEN BURNITE



327 HOSPITAL DRIVE #206
ALLEN BURNITE, MARYLAND 21024

MILVY T. BURNITE, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MILTON G LYNCH | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 28, 1983 | | | 2b. HOUR 0212 EST | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 13, 1909 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
74 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
COUNTRY
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Fed. Govt. | |
| 13a. STATE
North Car. | | | 13b. COUNTY
Eden | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
Rt. 1 Box 46a 99999 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hilary Lynch | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Exony Boyd | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE DATE OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
238-07-2698 | | | 17. INFORMANT
Tim Baker | | | ADDRESS
Md. 21032 La. Crownsville | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Septic**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **urinary tract infection**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Carcinoma of the bladder metastatic**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

osteoarthritis osteoporosis


| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 21 , 19 83 , to 10 28 , 19 83 , that (I) (we) lost saw the deceased alive on 10 28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mustafa Oz M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10 29 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MUSTAFA OZ M.D. | | 22e. ADDRESS
605 BALTO & ANNAP BLVD
SEVERNA PARK MARYLAND 21146 | | | | | |

| | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
Nov. 1, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ridge View | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Eden Rockingham N.C. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
T.A. Hardesty Annapolis Md. 21401 | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 1 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canfield | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| | | | | |
|--|------------------------------|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) CARL P. MANSON | | 2a. DATE KNOWN OF DEATH
ESTIMATED 10 15 83 | | 2b. HOUR
M 10 |
| 3. SEX
MALE | 4. RACE
CAU. | 5. DATE OF BIRTH
MONTH 11 DAY 14 YEAR 1924 | 6. AGE IN YEARS
(LAST BIRTHDAY) 59 YRS. | 7. IF UNDER 1 YR.
MONTHS 1 DAYS 14 HOURS 14 MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1798-A BELLE DRIVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ARCHEOLOGIST |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST CHARLES MIDDLE MANSON LAST MANSON | | 15. MOTHER'S MAIDEN NAME
FIRST AMELIA MIDDLE FASSLER LAST FASSLER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
526-10-6274 | | 17. INFORMANT
MARIAN F. MANSON ADDRESS
7406 ENGLEWOOD PL. ANNANDALE, VIRGINIA 22003 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCUD & Diabetes mellitus
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
William P. Jones | | TITLE (SPECIFY)
M.D. Deputy | | DATE SIGNED
15 Oct 83 |
| EXAMINER'S NAME
(TYPE OR PRINT)
William P. Jones MD | | ADDRESS
695 Americana Ct. Davidsonville | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
10-18-83 | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA FAIRFAX VA. |
| 24. FUNERAL DIRECTOR
NAME
ROBERT E. EVANS | | ADDRESS
1212 WEST ST. ANNAPOLIS MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 21 1983 |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel |



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|---------------------|--|---------------------|--|-------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| John | | | | | | Marich | | Oct | | 14 | | 83 | | | | 0600 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IN YEARS (LAST BIRTHDAY) | | 8. IF UNDER 1 YEAR | | 9. IF UNDER 24 HRS. | | | | | |
| MALE | | CAUC | | NOV 18 1914 | | 67 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE
(COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Wilkes-Barre Pa. | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Ann Arundel | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | |
| Pl. Meade | | Kimbrough Army Comm. Hosp. | | Army-Civ Serv | | US Gov. | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| md. | | Ann Arundel | | ODenton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 514 Rita | | 21113 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | |
| Peter | | Marich | | Eva. | | Cinn | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| yes | | WWII Korea | | 199 09 4820 | | Stella A. Marich | | Same as 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Pulmonary Failure | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | |
| 1629 | | DUE TO, OR AS A CONSEQUENCE OF | | (b) | | Pulmonary Carcinoma | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | C metastasis | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 3, 19 83, to Oct 14, 19 83, that (I) (we) lost
saw the deceased alive on Oct 14, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | 10-17-83 | | Md. Nat. Memorial Park | | Lanet | | PG. | | Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Hardesty Funeral Home | | Annapolis Md. | | OCT 14 1983 | | John J. Connelley | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

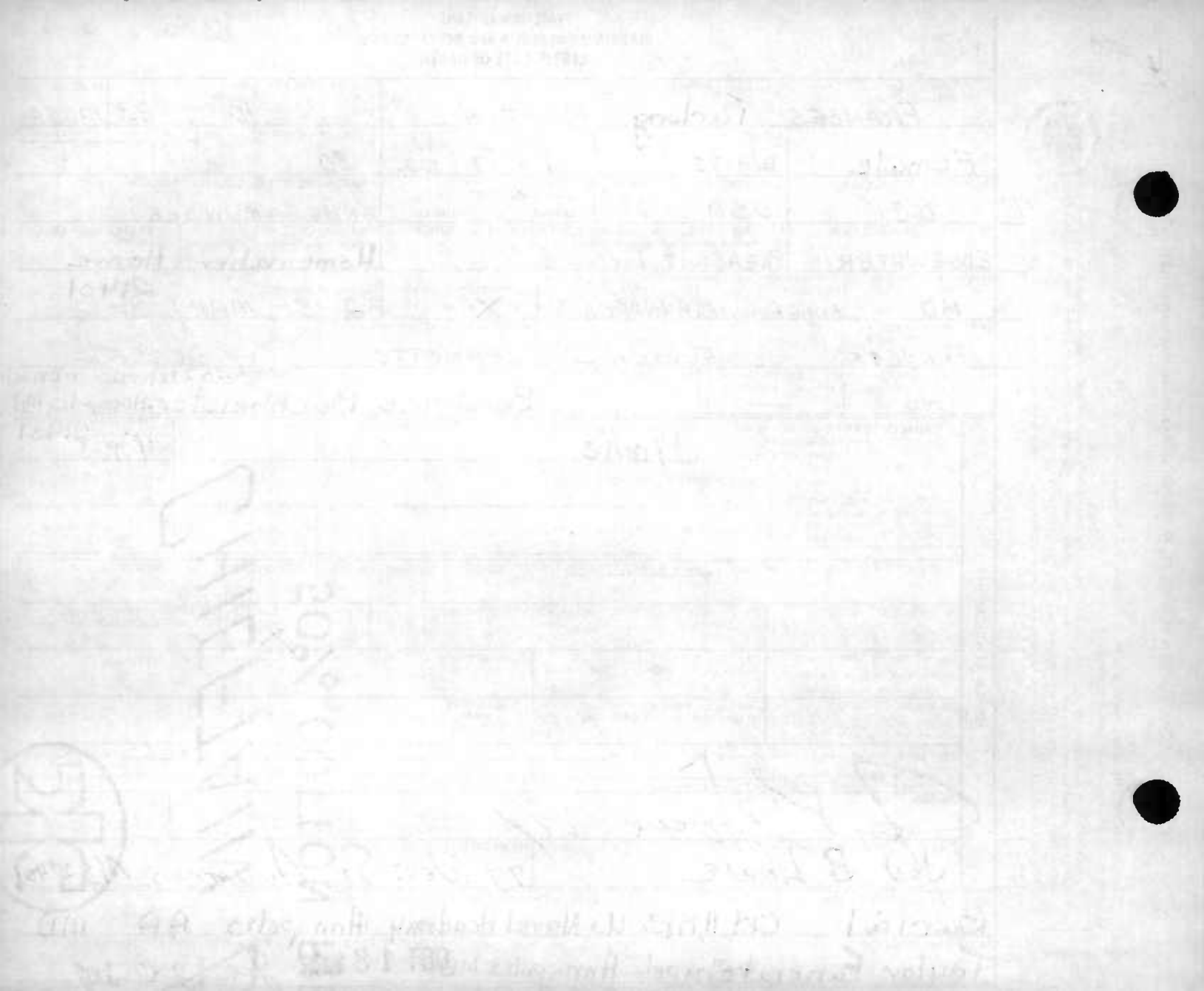
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FRANCES Furlong MARTIN | | | | | 2a. DATE OF DEATH
MONTH 10 DAY 7 YEAR 83 | | | | | 2b. HOUR
1205AM | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 11 DAY 17 YEAR 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEA MD | | | | | |
| 10. CITY OR TOWN OF DEATH
EDGEWATER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PHEASANT LIVING C.C. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
MD | | 13b. COUNTY
ANNE ARUNDEA | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2 ST. MARY ST. | | 21401 | |
| 14. FATHER'S NAME
FIRST FRANCIS MIDDLE LAST FURLONG | | | | | 15. MOTHER'S MAIDEN NAME
FIRST JEANETTE MIDDLE DESSEZ LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO.
 | | | | | 17. INFORMANT
Beatrice Buchheister ADDRESS 202 Wardour Drive Annapolis Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke
4360
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET OF DISEASE AND DEATH
4 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/9 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) lost see the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jon B. Lowe DEGREE | | | | | | | | 22c. DATE SIGNED
Oct 13 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jon B. Lowe | | | | | | | | 22e. ADDRESS
77 West St. Annapolis Md 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Oct 11, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
U.S. Naval Academy | | | 23d. LOCATION
CITY OR TOWN ANNE ARUNDEA COUNTY MD STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME Taylor Funeral Chapel - Annapolis, Md ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR
Oct 13 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 6 9

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JOSEPH (nmn) MARTIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 13, 1983 | | | 2b. HOUR
M
M | | | |
| 1. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 10, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Hanover | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1160 StoneyRun Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Automobile | |

| | | | | | | | | | | |
|--|--|--|---|--|-------------------------------------|---|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Hanover | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1160 StoneyRun Road 21076 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Martin | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Marks | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes W.W. II | | | | |
| 16b. SOCIAL SECURITY NO.
217-01-3706 | | | 17. INFORMANT (Sister)
Mrs. Teresa K. Holland Linthicum, Md. | | | ADDRESS 205 Twin Oaks Rd. | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Carcinoma lung-pleural effusion
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death

| | | | | | | | |
|---|--|---|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE
Dr. Malik A. Rehman | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE & KIND
10/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Malik A. Rehman | | 22e. ADDRESS
2717 Hammonds Ferry Road
Lansdowne, Maryland | | | | | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
October 17, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge, Howard, Md. | |
| 24. FUNERAL DIRECTOR
NAME
R. N. Hopkins | | ADDRESS
Singleton Funeral Home, Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
OCT 18 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|----------------------|--|--|---|-----------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELMER CHARLIE McCOLL | | | | | | | | | | 2a. DATE KNOWN OF DEATH 10/6/83 | |
| 3. SEX M | 4. RACE Cauc. | 5. DATE OF BIRTH 4-15-21 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 10/6/83 | | 2b. HOUR 11:50 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAH | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tree Trimmer | | 12b. KIND OF BUSINESS OR INDUSTRY Forresty | | | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Jennifer Rd 21401 | | | |
| 14. FATHER'S NAME Ross | | | | 15. MOTHER'S MAIDEN NAME Dora Neaves | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 238-30-271 | | 17. INFORMANT ADDRESS Ester Osbourn Rt. 3 West Jefferson N.C. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive brain damage
DUE TO, OR AS A CONSEQUENCE OF
(b) Trauma to head
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8147 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY 11:20 P.M. 10/6/83 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Struck by auto | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John E. Wheeler | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 10-7-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dr. Wheeler | | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10-11-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mock Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Creston Ash Co. NC. | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home ADDRESS Annapolis, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 14 1983 | | 25b. REGISTRAR'S SIGNATURE John E. Wheeler | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

25771

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>John Hickey Mc Namara, SR.</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>October 10, 1983</i> | | 2b. HOUR
<i>4:14 am</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>7 9 1892</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<i>91</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Pasadena</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>1315 Old Mountain Rd. 21122</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel</i> MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Inspector</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Dept. of Wts</i> | | | | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>Anne Arundel</i> | | 13c. CITY OR TOWN
<i>Pasadena</i> | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>1315 Old Mountain Rd. 21122</i> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Peter Paul Mc Namara</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary A. Cosgrove</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>Yes WW 1</i> | | 16b. SOCIAL SECURITY NO.
<i>096-32-6277 A</i> | | 17. INFORMANT
ADDRESS
<i>John Mc Namara same as # 13 e</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CHRONIC RENAL FAILURE</i>
1850
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>CARCINOMATOSIS, GENERALIZED</i>
(c) <i>CARCINOMA PROSTATE.</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 MO.</i>
<i>1 YR.</i>
<i>2 YRS</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>1-11-1952</i> to <i>6-12-1983</i> , that (I) (we) last saw the deceased alive on <i>6-12-83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Arthur Lankford, Jr. M.D.</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>10-11-83</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Arthur Lankford, Jr. M.D.</i> | | 22e. ADDRESS
<i>2934 Mountain Rd., Pasadena, Md. 21122</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>10-14-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Cross Cemetery</i> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Brooklyn New York</i> | | 23e. DATE REC'D. BY REGISTRAR
<i>OCT 14 1983</i> | | 23f. REGISTRAR'S SIGNATURE
<i>John J. Canine</i> | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Mc Cully Funeral Home 3204 Mountain Rd. 21122</i> | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 1 7 2

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BERTRAM Joseph Mc NELLY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 3 1983 | | | 2b. HOUR
M | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 19 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MAINE | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | | |
| 10. CITY OR TOWN OF DEATH
SEVERNA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
618 PINE TREE DR. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLAIMS REP. | | 12b. KIND OF BUSINESS OR INDUSTRY
SOCIAL SECURITY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
618 PINETREE DR. 21146 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH Edward McNELLY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CORA Emeline McLAUGHLIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1932-1962 004-40-2099 | | 17. INFORMANT
ADDRESS
ROSE McNELLY (SAME AS 13) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma of the colon
1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Renal Failure | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/27 , 19 83 , to 10/3 , 19 83 , that (I) (we) last saw the deceased alive on 9/15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Glenn F. Robbins, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
10-4-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Glenn F. Robbins, M.D. | | | 22e. ADDRESS
1404 CRAIN Hwy. So. Glen Burnie, Md 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
OCT. 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NAT'L Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON ARLINGTON VA. | | | |
| 24. FUNERAL DIRECTOR
NAME
BARRANCO, ROBERT S. | | | 501 RITCHIE HWY.
SEVERNA PARK, MD. | | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Givens | | |

MEDICAL CERTIFICATION

15

FOX COTTON
MILKIN



382 7 100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 7 3

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) John E Medley | | | 2a. DATE OF DEATH
MONTH DAY YEAR 10-17-83 | | 2b. HOUR
10:13^A |
| 3. SEX
M | 4. RACE
2 | 5. DATE OF BIRTH
MONTH DAY YEAR 3 10 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | |
| 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
HARWOOD | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST FRANCIS MEDLEY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST ROSIE DENT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
213-26-3626 | | 17. INFORMANT
ADDRESS 20776
ALICE MEDLEY 4350 Hopkins Rd. Harwood, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: acute myocardial infarction | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-17-83 to present , that (I) (we) last
saw the deceased alive on 10-17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
G Mitchell MD | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G Mitchell MD | | 22e. ADDRESS
205 R. Adams Ave Annapolis Md | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
10-20-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
PINELAWN MEM. PARK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
OCT 20 1983 John J. Gaherty | | | |
| 24. FUNERAL DIRECTOR
NAME WILLIAM REESE & SONS MORTUARY, P.A. | | 24b. ADDRESS
Annapolis, Md. 21401 | | | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10-17-72

10-17-72

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2041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 25774

| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
|---|--------|---|--|---|--|--|--|---|--|--|
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | MONTH | DAY | YEAR | | |
| ALBERT LLOYD MERRITTS | | | OCTOBER 30, 1983 | | | 1135 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| male | | white | | June 7, 1918 | | 65 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Tyrone Pa. | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | radio eng. | | radio station | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Fla. | | | Putnum | | Bostwick | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | P.O. Box 94 99999 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
Charles S. Merritts | | | FIRST MIDDLE LAST
Alice Burford | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| yes | | | W.W. II | | 717-12-2575 | | Steven Miller 7421 Locust Dr. Hanover, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 5778 IMMEDIATE CAUSE (a) SYSTEMIC CARDIOVASCULAR COLLAPSE | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) HEPATORENAL FAILURE; SEPSIS | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) SEVERE ACUTE HEMORRAGIC-NECROTIZING PANCREATITIS | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 10, 1983, to OCTOBER 30, 1983, that (I) (we) last saw the deceased alive on OCTOBER 30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d/d) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| PIO G. VALLE, JR., M.D. | | | | | | | | | 10-31-83 | |
| 22d. PHYSICIAN'S NAME (PRINT) | | | 22e. ADDRESS | | | | | | | |
| | | | 4730 MOUNTAIN ROAD, SUITE 1-4 PASADENA, MARYLAND 21122 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 11/2/83 | | Indian Town Gap National Cem. | | | Pa. | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Ann. Md. Hardesty Funeral Home 12 Ridgley AVE. | | | NOV 1 1983 | | | John J. Canine | | | | |

BP

24
10

101

DATE: OCTOBER 30, 1954

NAME: [illegible]

ADDRESS: [illegible]

CITY: [illegible]

STATE: [illegible]

ZIP: [illegible]

TELEPHONE: [illegible]

DATE OF BIRTH: [illegible]

SEX: [illegible]

RELIGION: [illegible]

REMARKS: [illegible]

FILED IN

COLLECTION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 1 7 5

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES D. MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-24-83 | | 2b. HOUR
10 AM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 22, 1900 | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
PA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
AA Gun Hosp MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A.A. Gun Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CABINET MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed |
| 13a. STATE
MD | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
PASADENA | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
8395 Old ANNAPOLIS | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
161143292 | | 17. INFORMANT
ADDRESS
above | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4960 Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Bronchitis
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Obstructive Pul. Dis. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1c.

| | | | | | |
|---|------------------------------|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 , 19 82 , to 10 , 19 83 , and that (II) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Arnold G. Alexander | | 22c. DATE SIGNED
10/24/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arnold G. Alexander, M.D. | |
| 22e. ADDRESS
650 Ritchie Hwy., Severna Park, MD | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
10-26-83 | 23c. NAME OF CEMETERY OR CREMATORY
Glenn Haven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glenn Burnside AA and | |
| 24. FUNERAL DIRECTOR
NAME
Robert S. Baranow | | ADDRESS
Summa Ph, Inc | | 25a. DATE REC'D. BY REGISTRAR
OCT 27 1983 | |
| 25b. REGISTRAR'S SIGNATURE
James J. Carver | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNIVERSITY OF MICHIGAN
JAN 10 1961

20% COTTON FIBRE
MADE IN U.S.A.



CC 15101

100% COTTON FIBRE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHRISTINE CECILIA MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 1, 1983 | | 2b. HOUR
700 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 24, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Hecht Co. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Peter Merski | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Constantina Andrzyjevska | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-9342 | | 17. INFORMANT
ADDRESS
Mrs. Carol P. Swimm, Same as # 13 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

5728 IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) Liver failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
MAR C KAPLAN | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| MAR C KAPLAN | | 7845 OAKWOOD ROAD, SUITE 200
GLEN BURNIE, MARYLAND 21061 | |

| | | | |
|---|---------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Oct. 5, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME
McCutty Funeral Home, Mt. & Ticker Rd. Pasadena | | 25a. DATE REC'D. BY REGISTRAR
OCT 3 - 1983 | 25b. REGISTRAR'S SIGNATURE
John J. Carver |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case.

| | | | | |
|--|---|--|--|--|
| <div data-bbox="235 20 332 114" data-label="Image"></div> | <div data-bbox="479 20 803 100" data-label="Text"> <p>RECEIVED
JAN 10 1964
U.S. AIR FORCE</p> </div> | | | |
| <div data-bbox="235 168 332 262" data-label="Image"></div> | <div data-bbox="479 168 803 262" data-label="Text"> <p>RECEIVED
JAN 10 1964
U.S. AIR FORCE</p> </div> | | | |
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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR Item 18c film 585
STATE REGISTRAR 11-10-83 en | | | | | | 83 25777 | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Lauren Nicole Moody | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 10 83 | | | 2b. HOUR
11:48 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 5 83 | | 6. AGE (IN YEARS LAST BIRTHDAY)
3 MO. YRS. 35 | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen'l Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN GAMARIS | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
1508 Laval Dr 21054 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dennis Moody | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Michele Loyet | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Carol Loyet 1599 Ridout Rd. Annapolis 21401 Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
4900
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchitis
DUE TO, OR AS A CONSEQUENCE OF (c) Compomelic dystrophy
Compomelic syndrome | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 10, 1983, to Same, 1983, that (I) (we) lost saw the deceased alive on Oct 10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural | | | | | | | | | | | |
| 22b. SIGNATURE
DONALD R SCHNEIDER | | | | | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/10/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD R SCHNEIDER | | | | | | 22e. ADDRESS
2538 Davidsonville Rd Annapolis MD 21054 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
10-11-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont Memorial Gardens Davidsonville Md. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Evans 1212 West St. Annapolis, Md. | | | | | | 25a. DATE REC'D BY REGISTRAR
OCT 21 1983 | | | | | |

MEDICAL CERTIFICATION

9
9

1

BR 301

| SECTION | | TOWNSHIP | | RANGE | | COUNTY | | STATE | |
|---------|----|----------|----|-------|----|--------|----|-------|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 |
| 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 |
| 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 |
| 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 |
| 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 |
| 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of an

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 83 25778 | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
FLORENCE E. MOORE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
Oct 12 1983 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
3 12 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 174
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOME, FACTORY, GIVE STREET ADDRESS)
981 ST. JOHNS DRIVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN
MD. A.A. Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
981 ST. JOHNS DR. 21401 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
GERDNER BARTHOLOMEW | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
BRANCH DARKER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
152 14 6413 | | 17. INFORMANT
EILEEN SCHILLER | | ADDRESS
13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) lung carcinoma
1629
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
M1 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26 , 19 83 , to 10/12 , 19 83 , that (I) (we) lost see the deceased alive on above (I) (we) did not view the body after death. and that (I) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE
Joseph N. Friend MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph N. Friend | | 22e. ADDRESS
205 Ridgely Ave Annapolis, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
10/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY
CEPAR Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BARTHAND P.G. MD. | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel | | ADDRESS
Annapolis Md | | 25a. DATE REC'D. BY REGISTRAR
OCT 17 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 7 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EDWIN R MOSLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-6-83 | | | 2b. HOUR 7P M. | |
| 3. SEX M | | 4. RACE E 1 | | 5. DATE OF BIRTH MONTH DAY YEAR 10-4-25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) TAVERN OWNER | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 1756 GENERALS HWY. 21401 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ERNEST C. MOSLEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY MAE CASE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | (IF YES, GIVE WAR OR DATES) WWII | | 16b. SOCIAL SECURITY NO. 241-30-3918 | | 17. INFORMANT ADDRESS SHEILA SCHLEMER ARNOLD, MD | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **HEPATOMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1975 , 19 to 10/6/83 , 19, that (I) (we) last saw the deceased alive on 10/6/83 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Stacy P. Walker Jr | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/10/83 | | 23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE V.A. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE A.A. MD | |
| 24 FUNERAL DIRECTOR NAME ADDRESS HARDESTY FUNERAL HOME ANNAPOLIS, MD | | | | 25a. DATE REC'D. BY REGISTRAR OCT 14 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



48/58 0 0

80 75-100



200%



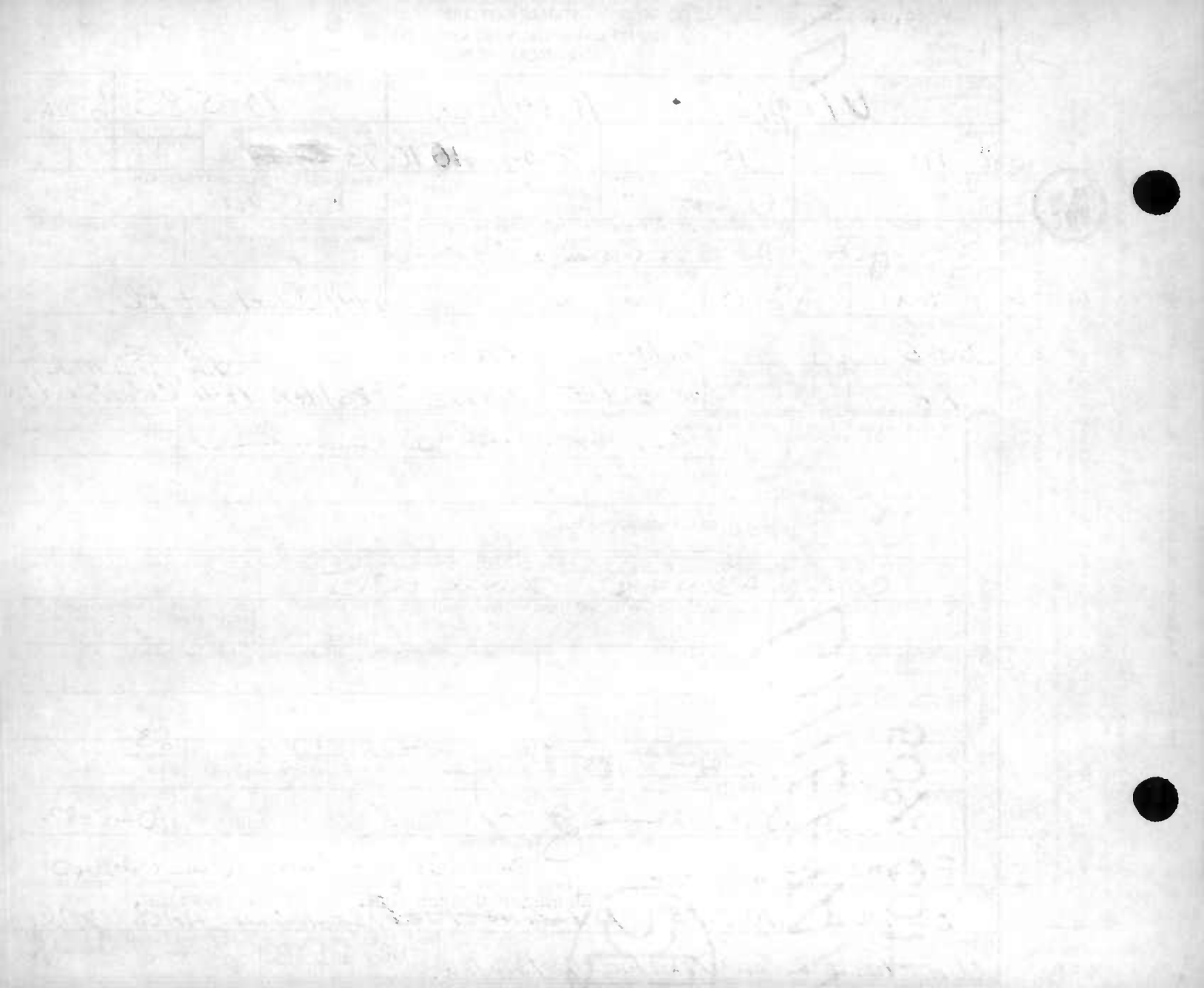
200%

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|-----------------------------------|-----|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE OF DEATH | | MONTH | DAY | YEAR | 20. HOUR | |
| 03. SEX | | 1. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 20. HOUR | | |
| m | | B | | 3-24-1933 | | 73 | | MONTHS | | DAYS | | HOURS | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 12b. HOUR | | |
| Baltimore | | USA | | | | BACO | | | | | | MD | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | | 13c. STATE | | |
| Baltimore | | Anne Arundel General | | | | | | 1441 Cedarhurst Rd | | Baltimore | | MD | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17a. ADDRESS | | 17b. CITY OR TOWN | | |
| Jacob | | Moulden | | No | | 208 03-2605 | | MARIE Moulden | | 1441 Cedarhurst Rd | | Baltimore | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 1629 | | Bone Marrow Cancer | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | COA, ASW, Chemo UTI | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | HOUR A.M. MONTH DAY YEAR | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | 21g. CITY OR TOWN | | 21h. COUNTY | | 21i. STATE | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | STREET | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. CITY OR TOWN | | 22g. STATE | | |
| 10-4-83 | | E. A. Shull | | 10-5-83 | | ERROZ A. Phillip | | 50 Ridgely Ave. Anne Arundel | | Baltimore | | MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. CITY OR TOWN | | 23f. COUNTY | | 23g. STATE | | |
| Burial | | 10-8-83 | | Mt Zion Church | | Galesville | | Luthian | | AACO | | MD | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. DATE REC'D BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | | 24e. CITY OR TOWN | | 24f. STATE | | |
| Wm. Reese & Son's Mortuary | | Ann M. Reese | | | | OCT 11 1983 | | John J. Connelley | | Baltimore | | MD | | |



BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST <u>Jeanne</u> MIDDLE <u>L.</u> LAST <u>Moulton</u> | | | 2a. DATE OF DEATH MONTH <u>OCT</u> DAY <u>9</u> YEAR <u>1983</u> | | | 2b. HOUR
M | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
MONTH <u>1</u> DAY <u>11</u> YEAR <u>1898</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>85</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>FRANCE</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Anne Arundel</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>ANNAPOLIS</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>701 GREENWOOD ST. APT 305</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOUSEWIFE</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE <u>MARYLAND</u> 13c. COUNTY <u>A.A. Co.</u> 13d. CITY OR TOWN <u>ANNAPOLIS</u> | | | | 13e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS
<u>701 GREENWOOD ST. APT 305</u> 21401 | |
| 14. FATHER'S NAME
FIRST <u>—</u> MIDDLE <u>—</u> LAST <u>—</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>—</u> MIDDLE <u>—</u> LAST <u>—</u> | | | |

| | | | | | |
|---|--|--|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>005 36 1895</u> | | 17. INFORMANT
ADDRESS <u>1008 Guy Dr.</u>
<u>GREENBELT MD.</u> | |
|---|--|--|--|--|--|

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
<u>2500</u> IMMEDIATE CAUSE (a) <u>Diabetes</u> <u>↑BP</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) <u>—</u> | |
| (c) <u>—</u> | | DUE TO, OR AS A CONSEQUENCE OF | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>H.D. Goldstein</u> M.D. | | | | DEGREE | | 22c. DATE SIGNED
<u>10/10/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>H.D. GOLDSTEIN</u> | | | | 22e. ADDRESS
<u>205 RIDGELY AVE ANNAPOLIS MD</u> 21401 | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | | 23b. DATE
<u>10/14/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>1st Parisit</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>YORK YORK MARYNE</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>TAYLOR FUNERAL CHAPEL ANNAPOLIS MD</u> ADDRESS <u>21401</u> | | | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>OCT 13 1983</u> <u>John J. Connel</u> | | | |

OCT 2 1968

FRANCE

WHITE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR AT 5 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANGELA Velma MYERS | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 19 83 | | 2b. HOUR 5:09 | | M AM | |
| 3. SEX Female B | | 4. RACE B | | 5. DATE OF BIRTH
MONTH DAY YEAR Aug 16 1953 29 YRS. | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 29 | | 7c. DATE PRONOUNCED DEAD 10 19 83 | | 7d. HOUR 5:09 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ANNAPOLIS | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher | | 12b. KIND OF BUSINESS OR INDUSTRY Car co | | | |
| 13a. STATE MD | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12 A Marcus Court | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Leon Myers | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Velma Catherine Dove | | | | 16. SOCIAL SECURITY NO. unkn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. unkn | | | | 17. INFORMANT ADDRESS Mrs Velma Weems 127 Chester Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 9660 Stab wounds of the chest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 10-19- 1983
P.M. 10-19- 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was stabbed. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE 15-A Marcs Ct. Annapolis Anne Arundel Md | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 10-20-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY PINE LAWN | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS C.E. Hicks III 1922 Forest Drive | | | | 25a. DATE REC'D. BY REGISTRAR OCT 25 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | |



Page 1 of 1

11/11/11

Mr. A. H. [illegible]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 8 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Samuel George Noel | | | 2a. DATE OF DEATH MONTH DAY YEAR
October 28, 1983 | | 2b. HOUR
2:55 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
July 28, 1905 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Tool & Die Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Carborundum |
| 13a. STATE
Pennsylvania | | | 13b. COUNTY
Westmoreland | 13c. CITY OR TOWN
Youngwood | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Alex Noel | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ida Ambrose | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
209-05-4280 | | 17. INFORMANT (son) ADDRESS
1604 Lorimer Rd.
Mr. Samuel K. Noel Glen Burnie, Md | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4960
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2. day
years |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-22 , 19 83 , to 10-28 , 19 83 , that (I) (we) last saw the deceased alive on 10-28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Samuel K. Noel | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10-29-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMUEL K. NOEL M.D. | | 22e. ADDRESS
95 Aqueduct Rd. Glen Burnie Md 21061 | | | |

| | | | |
|--|--------------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
November 1, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Westmoreland Co. Memorial Park | 23d. LOCATION
Hempfield Township Westmoreland Co. PA |
| 24. FUNERAL DIRECTOR NAME
B. H. Rappaport | | 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE
NOV 1 1983 John J. Canale | |
| 26. FUNERAL HOME
Singleton Funeral Home, Glen Burnie, Md | | | |



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to decipher but appear to include:]

[Handwritten signature or name, possibly "D. J. ...", in the lower right quadrant.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CAROLYN K. O'NEIL | | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 25 83 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
3 13 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Pasadena | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8498 Rugby Rd. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Designer | | 12b. KIND OF BUSINESS OR INDUSTRY
Flower | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Stanislaw J. Knopik | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Karolina Kuc | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
213-26-0964 | | 17. INFORMANT ADDRESS
Peggy Gilligan P.O. 464, Pasadena (21122) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration - respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma (L) lung</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1629 | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>(L) hemiplegia ; Atrial fibrillation, chronic</u> | | | | | | | |
| 19a. DATE OF OPERATION
12/20/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma (L) lung | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>70</u> to <u>25 Oct</u> 19 <u>83</u> , that (I) was last saw the deceased alive on <u>20 Oct</u> 19 <u>83</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>C. Earl J. Hill</u> DEGREE <u>MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
25 Oct 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME
George J. Gonce F.H. 4001 Ritchie Hwy. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 28 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Smith</u> | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| I. DECEASED NAME (TYPE OR PRINT)
HARRY NELSON OWENS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 25, 1983 | | | | |
| 3 SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
NOVEMBER 18, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7b. HOURS
2:30 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
LOTHIAN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
654 BAYARD ROAD | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
FARMER | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
LOTHIAN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
654 BAYARD ROAD 20711 | |
| 14 FATHER'S NAME
NELSON S. OWENS | | | | 15. MOTHER'S MAIDEN NAME
CLARA BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17 INFORMANT ADDRESS
DOROTHY V. OWENS SAME AS 13e | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
4275
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Coronary</u>
(c) <u>Due to, or as a consequence of</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>22 Oct</u> 19 <u>83</u> , to <u>25 Oct</u> 19 <u>83</u> that (I) (we) last saw the deceased alive on <u>22 Oct</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>William P. Jones, MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>25 Oct 83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William P. Jones MD | | | | | 22e. ADDRESS
4837 Solomons Isl Rd 20711 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
10-26-83 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION METHODIST CH. | | 23d. LOCATION
LOTHIAN ANNE ARUNDEL CO MARYLAND | | | |
| 24 FUNERAL DIRECTOR
ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS MD | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Smith</u> | | |

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30
24
20



Charles D. ...
...

William P. ...
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of this.

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|--|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JOSEPH E. PAINTER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 6, 1983 | | | | 2b. HOUR
1:25 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
APRIL 29, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNAPOLIS CONVALESCENT CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DECORATOR SELF | | 12b. KIND OF BUSINESS OR INDUSTRY
EMPLOYED | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND ANNE ARUNDEL ANNAPOLIS | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
113 BAY DRIVE 21401 | | | | | |
| 14. FATHER'S NAME
JOSEPH H. PAINTER | | | | 15. MOTHER'S MAIDEN NAME
ELIZABETH TREBARTHAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
214-05-1952 | | 17. INFORMANT ADDRESS
ESTHER A. PAINTER SAME AS 13E | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
4029
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardio-vascular disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>chronic</u>
<u>monthly</u>
<u>years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Chronic sinusitis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, HISTORY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (i) (the hospital) attended the deceased from <u>Jan 77</u> to <u>Oct 6 83</u> that (i) (we) last saw the deceased alive on <u>Oct 2 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>William Weintraub MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
10/7/83 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM WEINTRAUB | | | | 22d. ADDRESS
2568 A Riva Rd
104 FORBES STREET ANNAPOLIS, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
10-9-83 | | 23c. NAME OF CEMETERY OR CREMATORY
HILLCREST MEMORIAL PARK ANNAPOLIS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS ANNE ARUNDEL | | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS, MD | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 17 1983 | | | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | |

BP



[Faint, mostly illegible text and markings across the page, including what appears to be a signature or large stamp in the lower right quadrant.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Raymond Walton Palmer, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
October 22, 1983 | | | 2b. HOUR
6:30 A
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 15, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83
YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel
MD. | | | |
| 10. CITY OR TOWN OF DEATH
Linthicum | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
201 Sycamore Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Chemical Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Linthicum | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
201 Sycamore Road 21090 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin Palmer | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Bernard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215.09.1822 | | 17. INFORMANT
Son | | ADDRESS
Linthicum MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Transitional Carcinoma Bladder
1889
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from last several months , 19____, that (1) (we) lost recently , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James D. Biles MD
DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Oct. 22, 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James D. Biles MD | | | | | 22e. ADDRESS
Hospital Drive, Glen Burnie, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Oct. 25, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Mem Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll MD | | |
| 24. FUNERAL DIRECTOR
NAME Singleton Funeral Home, Glen Burnie, MD ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 25 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

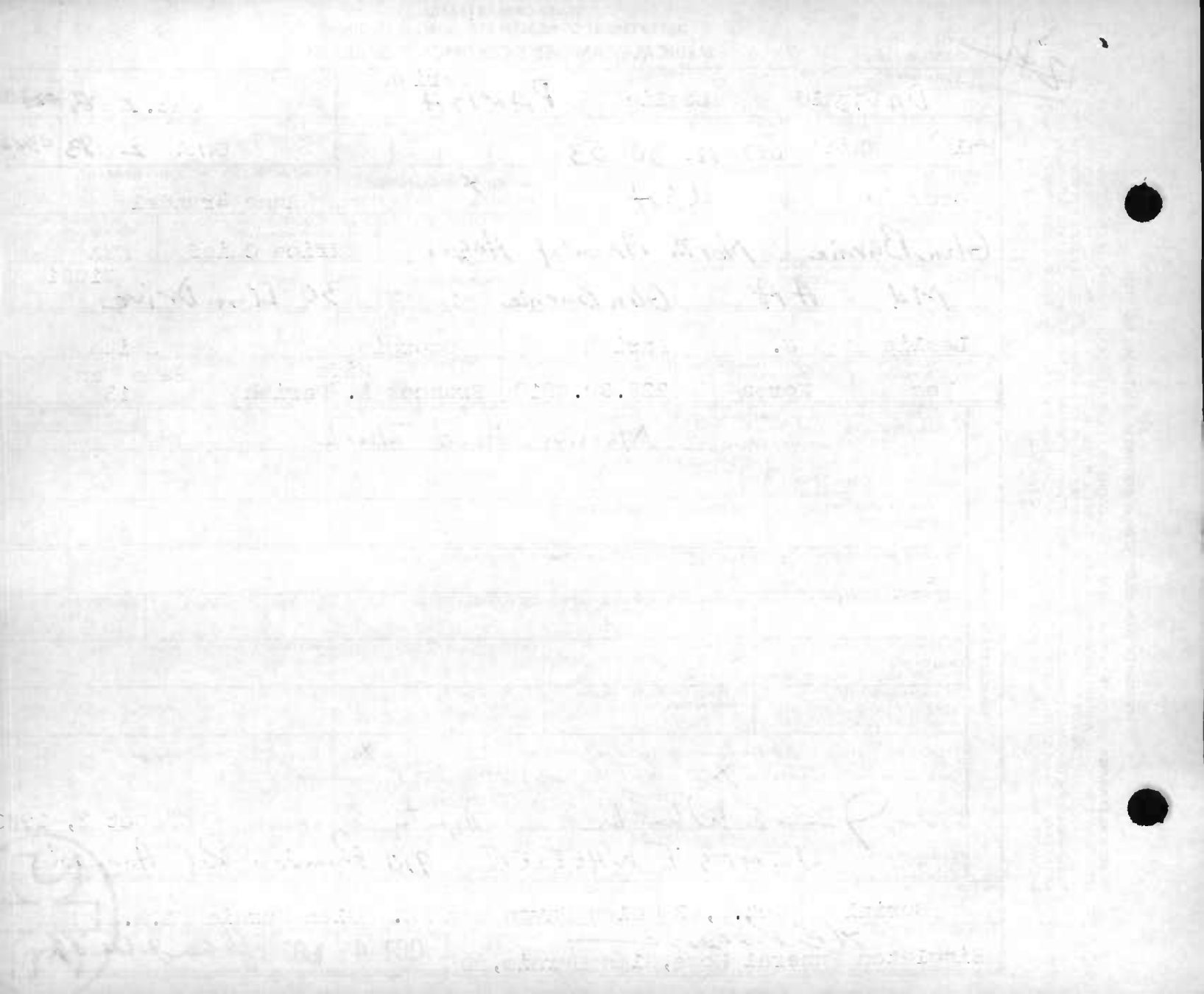
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|--------------------------------------|--|--------------------------|--|--|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Harold Leslie | | PARISH | | | | | | Oct. 2 1983 | | | | | | | | 0230 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | July 12 30 53 YRS. | | 53 YRS. | | | | | | Oct. 2 1983 | | | | | | 0342 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Georgia | | USA | | | | | | Anne Arundel | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Glen Burnie | | North Arundel Hosp. | | Office Chief | | NSA | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Md | | AA | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 30 Elm Drive | | | | | | | | 21061 | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | |
| Leslie J. Parish | | | | | | | | Georgie Smith | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Wife | | ADDRESS | | Same as | | | | | |
| Yes | | Korea | | 228.30.4910 | | Frances A. Parish | | | | | | 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Massive Heart Attack</u> | | | | | | | | | | | | | | | | | |
| 4100 | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TIME (SPECIFY) | | M.D. | | MEDICAL EXAMINER | | DATE SIGNED | | | | | | | | | |
| JAMES E WHEELER | | M.D. Deputy | | | | | | Oct 2, 1983 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| JAMES E WHEELER | | 910 Primrose Rd Annapolis | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Burial | | Oct. 5, 83 | | Glen Haven Mem Pk. | | Glen Burnie | | A.A. | | MD | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Singleton Funeral Home | | Glen Burnie, MD | | OCT 4 1983 | | John J. Canish | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | EDT | | |
|---|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALMA Florence PFEIFER | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 16, 1983 | | 2b. HOUR
MIN.
0645 PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 17, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21012 1592 Old Annapolis Road | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Arnold | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Griffin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alma Jane Parrish | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
ADDRESS
Alma Dillow (daughter) (same as 13) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2 hour | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic Shock | | | | | | | | 1 day | |
| DUE TO, OR AS A CONSEQUENCE OF (c) MI | | | | | | | | 1 day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Cerebrovas Insuff. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
7845 OAKWOOD ROAD SUITE 200 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/16 , 19 83 , to 10/16 , 19 83 , that (I) (we) last saw the deceased alive on 10/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
DAVID A. SCHWARTZ, M.D. | | | | | | 22c. DATE SIGNED
10/17/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Oct. 19, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cem. Baltimore, Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home Glen Burnie, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 18 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conish | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 7 9 0

EDT

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GRACE MARY PHELPS | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 28, 1983 | | 2b. HOUR
1130 PM | |
| 3 SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 31 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel M. Avara | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen M. Oppel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Husband
Ernest E. Phelps
ADDRESS
Same as 13 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4140

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC CARDIO MYOPATHY

DUE TO, OR AS A CONSEQUENCE OF

(c) HYPERTENSION & DIABETES MELLITUS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/28/1983 to 10/29/1983, that (I) (we) last saw the deceased alive on 10/28/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
K. Dharmasena | | DEGREE | | 22c. DATE SIGNED
10/31/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. DHARMASENA, M. D. | | 22e. ADDRESS
8 - 16TH AVENUE
BALTIMORE, MARYLAND 21225 | | | | | |

| | | | | | | | |
|---|--|------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Nov 1, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Friendship Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hanover AA MD | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, Md | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 1 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lohr | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 1

1500

• • • • •

10

Figure 2

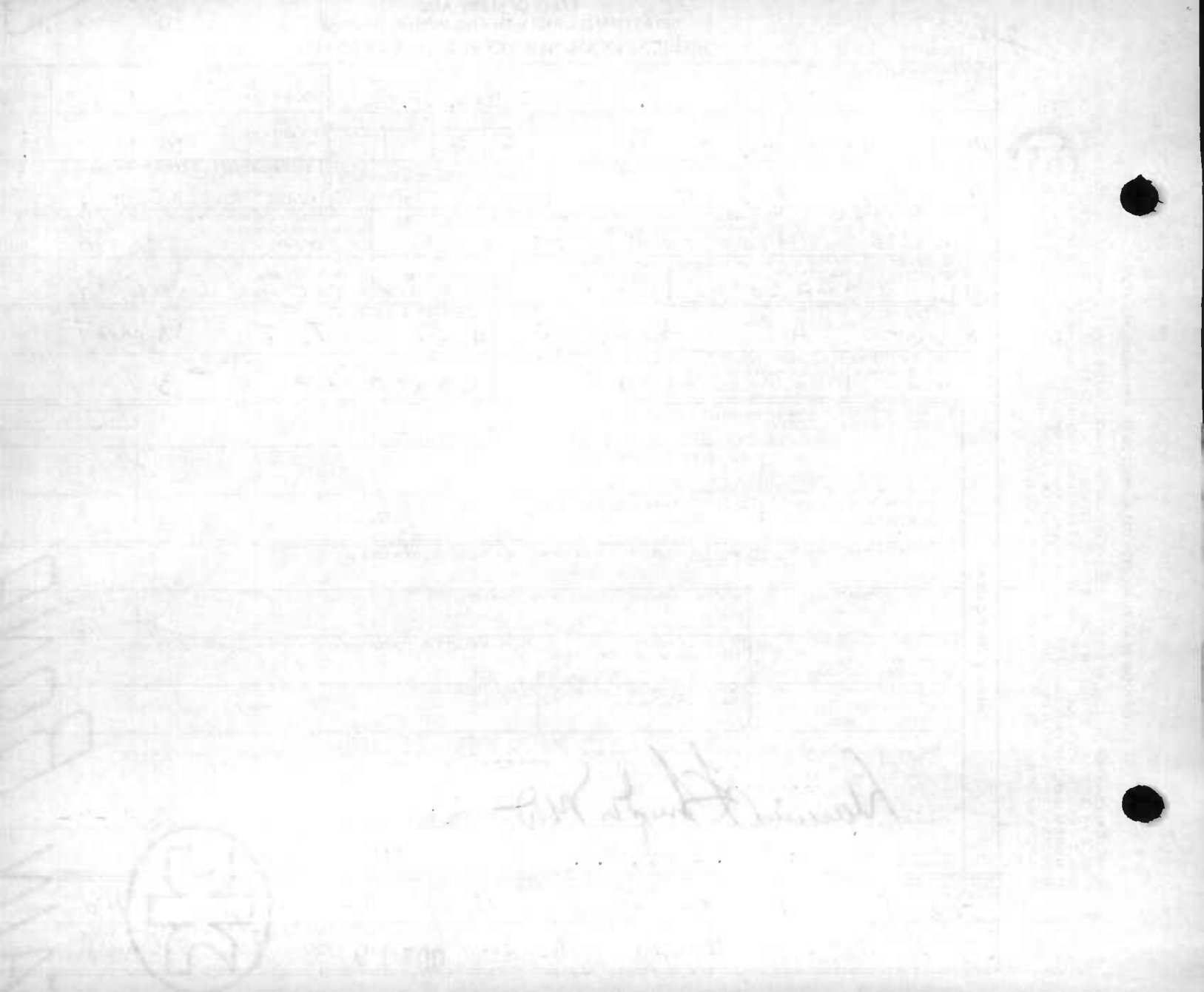
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|---|---|--|-------------------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert A. Phipps, Jr. | | | | | | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR 10 18 1983 | | 2b. HOUR 12:40 P. M. | | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR Aug 9 1983 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 9 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN 9 | 2c. DATE PRONOUNCED DEAD 10 18 1983 | | 24. HOUR 12:40 P. M. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Annapolis | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
n/a | | 12b. KIND OF BUSINESS OR INDUSTRY
n/a | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE md. 13b. CITY OR TOWN Deal | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Rock Hold Creek Rd. 20251 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Robert A. Phipps SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mary Jane Sheeher | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) n/a | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT
Robert A. Phipps SR. #13 | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
7980
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED 10-19-83 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE 10-21-83 | | 23c. NAME OF CEMETERY OR CREMATORY Friendship U.M. | | 23d. LOCATION
(CITY OR TOWN) Friendship | | COUNTY Md. | | STATE | |
| 24. FUNERAL DIRECTOR
T. A. HARDESTY | | | | ADDRESS
Annapolis Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR 10 OCT 19 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Sylvester Pinkney | | | 2a. DATE OF DEATH MONTH DAY YEAR
October 11 1983 | | | 2b. HOUR
5:29 PM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 5 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21403 1185 Madison St. Apt A4 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN PINKNEY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RACHEL JONES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-05-1989 | | 17. INFORMANT
ADDRESS
Annapolis, Md. 21403
IRIS JONES 1140 Madison St. Apt. S 1 | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition - Sepsis
1509
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the esophagus 1 yr -
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3-months | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) Dr. Gary M. Richardson attended the deceased from July 1980 to 11 Oct. 1983 that (ii) he last saw the deceased alive on 11 October 1983 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (b) viewed (c) viewed the body after death | | | | | | | |
| 22b. SIGNATURE
GARY M. RICHARDSON, M.D. | | | | DEGREE | | 22c. DATE SIGNED
10-11-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GARY M. RICHARDSON, M.D. | | | | 22e. ADDRESS
101 Forbes Street, Annapolis, Md. 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-17-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
PINELAWN MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland | |
| 24. FUNERAL DIRECTOR
WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 14 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Gough | | | | | | | |



COMPTON, ALLEGAN

10-10-1910

10-10-1910

10-10-1910

10-10-1910

10-10-1910

10-10-1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | JENNIE MAE POTOCKI | | 10/27/83 8 ³⁰ A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | MONTH DAY YEAR
06 15 03 | | 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| SEVERNA PARK | | 836 CREEK VIEW ROAD, 21146 | | CIVIL SERVICE | | DEPT. OF DEFENSE | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | A.A. | | SEVERNA PARK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 836 CREEK VIEW ROAD, 21146 | | | |
| WLADYSLAW | | VICTOR | | ALBERTA | | CWALINA | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 219-18-3825 | | THADDEUS W. POTOCKI | | SEVERNA PARK, MD.
836 CREEK VIEW ROAD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>
<u>2396</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>BRAIN TUMOR</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4-7 PM</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| - | | - | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>NA</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | <u>NA</u> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> , to <u>Oct 27</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Oct 17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| <u>N.A. Capozzoli MD</u> | | | | 22d. ADDRESS | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | 22f. DATE SIGNED | |
| <u>Nicholas Capozzoli MD</u> | | <u>25 Shaw St. Maryland Md. 21401</u> | | | | <u>27 Oct 1983</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 10-31-83 | | BALTIMORE NATIONAL | | BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | 21229
OCT 28 1983 | | <u>[Signature]</u> | | | |

BP



CHAMPAIN

20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | 83 25 / 94 | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>CLAUDE J. Prewett</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>10 22 83</i> | | 2b. HOUR
<i>11 A</i> M | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>CAUC.</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 8 74</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>84</i> | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Alabama</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Millersville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Kearwood Manor Lgs. Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Mechanic</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Body Repair</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MD</i> 13b. COUNTY <i>A.A.</i> 13c. CITY OR TOWN <i>Annapolis</i> | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>1950 Fairfax Road-21401</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>C. D. Prewett</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Josephine Dempsey</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>214-05-0072</i> | | 17. INFORMANT
ADDRESS
<i>Mary E. Prewett - 1950 Fairfax Rd Annapolis, MD 21401</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i>
<i>4292</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<i>Septic Secondary To Infected Decubitus Ulcers</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>10/24/83</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Septic Secondary To Infected Decubitus Ulcers</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Barry R. Nathanson</i> | | | | DEGREE
<i>M</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>10/24/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Barry R. Nathanson</i> | | | | 22e. ADDRESS
<i>51 Franklin St Annapolis, MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
<i>Burial</i> | | 23b. DATE
<i>Oct 26, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Hillcrest</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Annapolis A.A. MD</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Taylor Funeral Chapel - Annapolis, MD</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 26 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARTHA J PULLER | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 12 4 1983 | | | 2b. HOUR
10:20 A.M. | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUS | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 24 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ALA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. Co. MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SHIP FACILITY, GIVE STREET ADDRESS)
A.A. Gen. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
THERAPIST | | 12b. KIND OF BUSINESS OR INDUSTRY
SPEECH | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ARNOLD | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1643 OLD ANNAPOLIS RD | | | | | | |
| 14. FATHER'S NAME
FIRST ROSS MIDDLE BLANTON LAST BLANTON | | | | | 15. MOTHER'S MAIDEN NAME
FIRST NANCY MIDDLE BARNARD LAST BARNARD | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES)
WWII | | | | | 16b. SOCIAL SECURITY NO.
417202555 | | | | | 17. INFORMANT
KENNETH PULLER - ABOVE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
9/24 83 | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
10/24 83 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24 1983 to 10/24 1983 , that (I) (we) lost saw the deceased alive on 10/24 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
E. W. Cole DEGREE | | | | | | | | 22c. DATE SIGNED
10/24/83 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. W. COLE III | | | | | | | | 22e. ADDRESS
57 FRANKLIN ST ANNAP MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
10-27-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Rocky Mt. Bapt. Ch. ARAB | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MARSHALL ALA. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert S. Baranco | | | | ADDRESS
2nd 21146 Severna Pk | | DATE REC'D. BY REGISTRAR
OCT 27 1983 | | REGISTRAR'S SIGNATURE
John J. Givens | | | | | | |

BP



RECEIVED
JAN 10 1975

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text block]

11/11/74

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME FOR PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---------------------------------|--|--|--|--|--|---|--|-------------------------------|--|---|--|---|--|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. DATE OF DEATH | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| | | AKA FIRST Raymond Melvin MNN LAST Putnam Putnam | | Male | | White | | 7 18 38 45 YRS. | | MONTH DAY YEAR | | IF UNDER 24 HRS. | | 10/23/83 | | Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS | | 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | |
| Glen Burnie | | North Arundel Hospital | | Sales Clerk | | Retail | | Maryland | | Anne Arundel | | YES X NO | | 3509 Wines Lane 20707 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| Thurman Forrest Putnam | | Fannie May Wilson | | YES NO | | 272-32-2874 | | Dorothy Payton | | PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d) Arteriosclerotic Cardiovascular Disease | | | | | | | |
| Unknown | | Unknown | | YES NO | | Unknown | | Unknown | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 22a. I certify that I took charge of the remains described above, held on | | 22b. DATE | | 22c. NAME OF CEMETERY OR CREMATORY | |
| | | | | YES X NO | | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | Autopsy X Inspection Inquiry and in my opinion | | 10/27/83 | | Riverview Cemetery | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 22a. I certify that I took charge of the remains described above, held on | | P.M. | | 22b. DATE | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION | | 22e. DATE REC'D. BY REGISTRAR | |
| WHILE AT WORK NOT WHILE AT WORK | | STREET, FACTORY, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | Natural causes X Accident Suicide Homicide Undetermined manner | | 22b. DATE | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION | | 22e. DATE REC'D. BY REGISTRAR | | 22f. REGISTRAR'S SIGNATURE | |
| | | | | | | TITLE (SPECIFY) | | M.D. Assistant | | DATE SIGNED | | 10/24/83 | | Ann M. Dixon, M.D. | | 111 Penn St., Balto., Md. 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | 24b. DATE | | 24c. NAME | |
| Burial | | 10/27/83 | | Riverview Cemetery | | Strasburg, Shenandoah VA | | OCT 28 1983 | | Ann M. Dixon, M.D. | | Capitol Funeral Service Falls Church, VA 22040 | | 10/27/83 | | Ann M. Dixon, M.D. | |

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

10-20

RECEIVED

NOV 10 1963

215

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

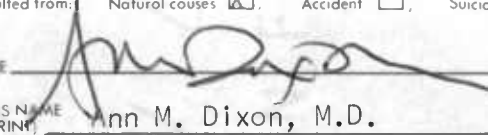

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|-------------------------------------|---------|------------------|---|----------------|------------------|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE KNOWN OF DEATH | | | 2c. DATE PRONOUNCED DEAD | | |
| John Leo Radecke Jr. | | | 10-1-83 | | | 10-1-83 | | | 1200 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | |
| M | W | 4-15-55 | 57 YRS. | | | Md | | | US | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Brooklyn | | | 4 Rene Ave. Brooklyn | | | Ret | | | Insurance | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Md | | | A.A. | | | Brooklyn | | | YES X NO | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | |
| John L. Radecke Sr | | | Victoria Hogeniecki | | | Yes | | | 219-16-3244 | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| Margaret Ann Radecke | | | Heart attack | | | 10-5-83 | | | | | |
| Address: 649 FA Co. | | | Pulm. edema | | | | | | | | |
| 20. AUTOPSY? | | | 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | |
| YES NO X | | | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | HOUR A.M. MONTH DAY YEAR | | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | |
| | | | | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | 22a. I certify that I took charge of the remains described above, held an | | |
| WHILE AT WORK NOT WHILE AT WORK | | | STREET, FACTORY, FARM, ETC.) | | | STREET CITY OR TOWN COUNTY STATE | | | Autopsy Inspection Inquiry and in my opinion | | |
| | | | | | | | | | death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Burial | | | 10-5-83 | | | St. Stanislaus Cem | | | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | 26. DATE OF DEATH | | |
| Fawley Funeral Home | | | 6601 Frederick | | | John J. Connel | | | 10-1-83 | | |
| NAME ADDRESS | | | CITY OR TOWN STATE | | | DATE | | | SIGNATURE | | |
| | | | Catonville 21228 | | | OCT 6 1983 | | | | | |

G#585 11/10/83 Items 18-22a

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|------------------|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROY Lee RADCLIFF | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
10 5 19 83 | | | 2b. HOUR
5:32 P M | | | |
| 1. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
3/25/48 | 6. AGE (IN YEARS LAST BIRTHDAY)
35 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
10 5 19 83 | | | 2d. HOUR
5:32 P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Weston W.Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Harwood | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
1501-G Flanders Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
a.A. Co. | | 13c. CITY OR TOWN
Harwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1501 G Flanders Lane 20796 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joe Radcliff | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Betty Burr | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
67-71 | | 17. INFORMANT
ADDRESS
Sandra K. Radcliff 1501 G Flanders Harwood Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Seizure disorder</u>
7803
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED
10-6-83 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn Cemetery Weston, W.Va. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | | | ADDRESS
12 Ridgely Ave.
Ann. Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR
OCT 10 1983 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

OLSON, HIRSH

100-100000-100000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3

2 5

1 9 9

FOR
1. STATE
REGISTRAR

REG. NO.

EDT

| | | | | | | |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH RAKOWSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 13, 1983 | | 2b. HOUR
2:20PM | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 17, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
--- |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
A.A. Co | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Felix Rakowski | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1921-1927 | | 17. INFORMANT
ADDRESS
Alan Legum 208 Duke Gloucester St. Ann. Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA, CRF, DIC
4280
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CHF
DUE TO, OR AS A CONSEQUENCE OF
(c) --- | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 83 , to 10/18 , 19 83 , that (I) (we) last saw the deceased alive on 9/13 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Hamid A. Towhidian, M.D. | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAMID A. TOWHIDIAN, M.D. |
| 22e. ADDRESS
3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122 | | | | 22f. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/18/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Bluff Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ann. Md. |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
10/19/83 | | 25b. REGISTRAR'S SIGNATURE
John J. Davis |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If necessary be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NOT

3:30P

OCTOBER 13, 1983

BAROWSKI

JOSEPH

DAVE ARTHUR COUNTY

WORTH MOUNTAIN HOSPITAL

CLIN BUNNIE

3236 MOUNTAIN ROAD
PARADISE, ARIZONA 85936

HOWARD A. TOWNSEND, M.D.

CEMETERY

1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once!

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|---|--|--|--|---|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Kenneth W. Redd | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 04 83 | | | |
| 3. SEX m | | | | | 2b. HOUR 2:20 AM | | | |
| 4. RACE w | | | | | 5. DATE OF BIRTH MONTH DAY YEAR
6 5 22 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL General | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Automobile Bodyman | | | |
| 13a. STATE Md. | | | | | 13b. CITY OR TOWN Edgewater | | | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13d. STREET ADDRESS 1715 Fairhill Dr., 21037 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Dewey Redd | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elsie Swann | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT ADDRESS
Lillie Redd, Wife, Same as Above | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiogenic shock
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ventricular fibrillation-recurrent
(c) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 hrs.
yes. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
1) Severe COPD 2) Diabetes mellitus | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/13/83 to 10/14/83 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did/did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Joseph N. Friend | | | | 22c. DATE SIGNED 10/14/83 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 205 Ridgely Ave Annapolis, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10-8-83 | | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland, P.G., Md. | | | | 23e. DATE REC'D. BY REGISTRAR 10/13/83 | | | | 23f. REGISTRAR'S SIGNATURE John E. Friend |
| 24. FUNERAL DIRECTOR NAME Robt E Wilhelm | | | | 24b. ADDRESS 4308 Suitland Rd., Suitland, Md. | | | | |

BP

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10-11-55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

item 15 & 16a #G585 11/4/83 ph STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. EST

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
LEE ROY REED | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 30, 1983 | | | 2b. HOUR
245 AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 12 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IN NORTH MARYLAND, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter Retired | | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Glen Burnie | | 13c. STREET ADDRESS
1123 Crawford Drive 21061 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Houston Reed | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Virginia Clay Flippo Clay | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
1922-1925 421-14-1370 | | 17. INFORMANT
Fannie M. Reed, Same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
5850 IMMEDIATE CAUSE (a) Chronic Respiratory Appt
(b) Respiratory and Metabolic Disturb
(c) Chronic Renal Failure & Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours Days Months | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-30-83 to 10-30-83, that (I) (we) last saw the deceased alive on 10-30-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Hilary T. O'Herlihy | | | | DEGREE
M.D. | | 22c. DATE SIGNED
10-30-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HILARY T. O'HERLIHY | | | | 22e. ADDRESS
325 HOSPITAL DRIVE, SUITE 208
GLEN BURNIE, MARYLAND 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
11/1/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Elkridge Howard MD | | |
| 24. FUNERAL DIRECTOR NAME
James S. Kirkley, Glen Burnie, MD | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | |

IN SENATE, JANUARY 1, 1901.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1899.

ALBANY: J.B. KNEELAND, STATE PRINTER, 1901.

THE LAND OFFICE, ALBANY, N. Y.

ALBANY, N. Y., JANUARY 1, 1901.

TO THE SENATE, ALBANY, N. Y.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1899.

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ALBANY: J.B. KNEELAND, STATE PRINTER, 1901.

THE LAND OFFICE, ALBANY, N. Y.

ALBANY, N. Y., JANUARY 1, 1901.

TO THE SENATE, ALBANY, N. Y.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|-----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILMA Pearl ROBERTS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10/24/83 | | 2b. HOUR
11:45 AM | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 28 19 63 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE
(COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Booker | | 12b. KIND OF BUSINESS OR INDUSTRY
Accounting | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilmer E. Swift | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Viola Pearl Stewart | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
578-16-2668 | |
| 17. INFORMANT
Betty L. Halley | | 18. ADDRESS
518 Lower Terrace
Huntington, WVA 25765 | | 19. DATE OF OPERATION | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED | |

18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Renal Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK NOT AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
H. Goldstein | | | | DEGREE | | 22c. DATE SIGNED
10/24/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. D. Goldstein, MD | | | | 22e. ADDRESS
Monteney Ave. Annapolis, MD | | | |

| | | | | | | | |
|--|--|---------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Oct 26 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Fl. Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel - Annapolis, MD | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 26 1983 | | 25b. REGISTRAR'S SIGNATURE
Shan E. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILLIAM J. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JACOB J. ROSENBERG | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 10-6-83 | | | 2b. HOUR
4:30 PM | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR Dec 8, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR ORIGIN)
N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES | | 12b. KIND OF BUSINESS OR
INDUSTRY
LUMLER | | |
| 13a. STATE
MD | | | | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
GLEN BURNIE | | 13d. STREET ADDRESS
105 HARTFORD RD. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
209-09-7007-A | | 17. INFORMANT
ADDRESS
RENA HORAK - ABOVE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease | | | | | | | | | | |
| (b) 4100 | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis general | | | | | | | | | | |
| (c) 5 yrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/28 , 19 72 , to 10/6 , 19 83 , that (I) (we) last saw the deceased alive on 10/4 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Joseph Taler, M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Oct 7, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH TALER | | | | | 22e. ADDRESS
95 HANNAH RT. Glen Burnie, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| BURIAL | | 10-7-83 | | Hillcrest Cem | | Annapolis A.A. Md | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert J. Barenco | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 11 1983 | | | | | |
| ADDRESS
Severna Park | | | | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | | | | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 83 25804 | | | |
|--|--------------------|--|---|--|---|--|------------------------------------|---|---|--|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) James B. Rothnie | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10 8 83 | | 2b. HOUR 1430 | |
| 1. SEX M | 4. RACE CAU | 5. DATE OF BIRTH 10 8 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD 19 | | 2d. HOUR M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Col. U.S. Army | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE VA. | | 13b. COUNTY Arlington | | 13c. CITY OR TOWN -- | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 329 North Edison St. | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) James Rot hnie | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) MARY Bell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1942-56 224-60-884 | | 17. INFORMANT MARY Donnelly (Daughter) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 0000
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones, M.D. | | | TITLE (SPECIFY) Deputy Medical Examiner | | | | | | DATE SIGNED 10-15-83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | | ADDRESS 695 America Ct. Davidsville | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA. | | | | | |
| 24. FUNERAL DIRECTOR Murphy Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 24 1983 | | 25b. REGISTRAR'S SIGNATURE Joan J. Connel | | | | | |

MEDICAL CERTIFICATION

BP 304

RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 0 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ervin FRANK Rupp | | | 2a. DATE OF DEATH MONTH DAY YEAR
10 20 83 | | 2b. HOUR
3:45 AM |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
6 14 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VA. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Cinnapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
EXECUTIVE | | 12b. KIND OF BUSINESS OR INDUSTRY
TRUCKING |
| 13a. STATE
MD. | | 13b. COUNTY
H.A. Lothian | 13c. CITY OR TOWN
306 Berts Dr. | 13d. STREET ADDRESS
20711 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM Rupp | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTHA ARNDT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
223051842 | | 16c. HOME ADDRESS
306 BERTS DR. LOTHIAN MD. 20711 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Dist**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Chronic Obstructive Pulmonary Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 19 81 to OCT 20 19 83 , that (I) (we) last saw the deceased alive on OCT 19 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
BARRY R. NATHANSON MD | | DEGREE | | 22c. DATE SIGNED
10/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY R. NATHANSON | | 22e. ADDRESS
51 FRANKLIN ST. ANNAPOLIS MD 21401 | | | |

| | | | |
|---|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
10/24/83 | 23c. NAME OF CEMETERY OR CREMATORY
HILLCREST CEM. | 23d. LOCATION
CITY OR TOWN COUNTY
ANNAPOLIS AA. MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Care Annapolis MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 24 1983 | 25b. REGISTRAR'S SIGNATURE
James G. Conner |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

Items #5&6

FOR Film G585 11/3/83 jp
1. STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 0 6

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM JEFFERSON SANGSTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR 10-6-83 | | | 2b. HOUR
9:14 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR 4-14-28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) KANSAS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A-A Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
GIEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH HAVENDEL HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) ENG | | 12b. KIND OF BUSINESS OR INDUSTRY
WESTINGHOUSE | |
| 13a. STATE
MD | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
SEVERNA PK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
347 PRESWICK WAY | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WM J. SANGSTER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DOROTHY SIFERS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO.
WWIL | | 17. INFORMANT
ADDRESS
NANCY SANGSTER - ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uterine Ectomy
3920
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Pneumonic Mitral Stenosis
DUE TO, OR AS A CONSEQUENCE OF
(c) 1967 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the physician) attended the deceased from 8/24 , 19 79 , to 10/6 , 19 83 , that (I) (we) lost saw the deceased alive on 9/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Cliff Katliff, Jr. MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
10/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CLIFF KATLIFE, JR. MD | | | | | | 22e. ADDRESS
BALTIMORE, MD - 31338 | | | |
| 23a. BURIAL CREMATION, REMOVAL
(SPECIFY) CREMATION | | | 23b. DATE
10-7-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crem | | 23d. LOCATION
CITY OR TOWN STATE
Westview Park Md | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Baranov | | | | | | ADDRESS
Severna Pk | | 25. DATE REC'D. BY REGISTRAR
OCT 11 1983 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Samuel C. C... | | | |

20% COTTON

CHIT-AM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | EDT | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
FRANK HOWARD SARGENT | | | | MONTH DAY YEAR
OCTOBER 24, 1983 | | | | 555 PM | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 30 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PERSONNEL OFFICER | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN SEVERNA PARK | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
115 ST. ANDREWS RD. 21146 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HOWARD SARGENT | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELEN SIMMONS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW II | | | | 16b. SOCIAL SECURITY NO.
092-12-3852 | | 17. INFORMANT
ADDRESS
RUTH Q. SARGENT (SAME AS 13) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4275 IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30-60 minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
1) Staphylococcus pneumoniae 2) Spontaneous Pneumothorax | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24-83 , 19 83 , to 10-26-83 , 19 83 , that (I) (we) lost saw the deceased alive on 10-24 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
HILARY T. O'HERLIHY M.D. | | | | DEGREE | | | | 22c. DATE SIGNED
10-26-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
325 HOSPITAL DRIVE, SUITE 208 GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
OCT. 28, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
ELMWOOD HILL Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
TROY PENNSELER N.Y. | | | |
| 24. FUNERAL DIRECTOR
NAME
BARRANCO FUNERAL HOME | | | | 24a. DATE REC'D. BY REGISTRAR
OCT 27 1983 | | 24b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | EDT | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EVELYN Mae SCHAEFER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 18, 1983 | | | | 2b. HOUR
10:08A M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 22, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8443 Lyndale Dr. 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Jones | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
213.50.2461 | | 17. INFORMANT
Daughter | | ADDRESS
Dorothy E. Schaefer | | Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforation, Sigmoid Colon
5698
DUE TO, OR AS A CONSEQUENCE OF
(b) Stercoral Ulcer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a
old cerebrovascular accident | | | | | | | | | | | |
| 19a. DATE OF OPERATION
10/11/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Perforation Sigmoid Colon | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 3, 1983 , to Oct 18, 1983 , that (I) (we) last saw the deceased alive on Oct 18, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Arthur L. Gudwin M.D. | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Oct 18, 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARTHUR L. GUDWIN, M.D. | | | | 22e. ADDRESS
7310 RITCHIE HIGHWAY
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Oct 21, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
H B Vason | | | | ADDRESS
Singleton Funeral Home, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lohr | | | |

END

OCTOBER 18, 1963 10:00A

SCHULTZ

PH. N.

WELSH

20, 1963

WILLIAM ARTHUR COUNTY

NORTH ARTHUR HOSPITAL

WELSH

WILLIAM

6413 LINDSEY DR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALMA B SCHULTZ | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-6-83 | | 2b. HOUR
10:40 M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-09-03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rufus R. Bolt | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie F. Kent | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
701 Glenwood St. 21401 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
118-07-1666A | | 17. INFORMANT
ADDRESS 3912 Conifer Lane
Bowie, Maryland | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
1991
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastatic Carcinoma
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____
DUE TO, OR AS A CONSEQUENCE OF _____
DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-4 , 19 83 , to 10-6 , 19 83 , that (I) (we) last saw the deceased alive on 10-4 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. Caputo | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
10-2-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. CAPUTO MD | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Oct. 10 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeside Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hamburg, New York | |
| 24. FUNERAL DIRECTOR
NAME R. Beall ADDRESS 16000 Annapolis Rd. Bowie, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| John Tucker Scott | | | 10-15-83 | | 81 | | 30A | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | Caucasian | | Dec. 2 1901 | | 81 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | USA | | | | Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Crofton | | 1566 Farlow Avenue | | | | Self employed | | Clothier | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Anne Arundel | | Crofton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1566 Farlow Ave 21114 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| John Henry Scott | | | Nola Blanche Charles | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | |
| no | | | 224-05-3123 | | Betty R. Dosek | | same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> | | | | | | | | | |
| 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe C.O.P.D.</u> | | | | | | | | | 1 month |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/13/83</u> to <u>10/15/83</u> , that (I) (we) last saw the deceased alive on <u>10/13/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Carol Pressey</u> | | | MD | | | | | 10-15-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| Carol Pressey MD | | | 3 Village Green, Crofton, Maryland 21114 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 10-18-83 | | Peninsula Memorial Pk. | | Newport News, Virginia | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Beall Funeral Home | | | 16000 Annapolis Road | | | OCT 18 1983 <u>John E. Powell</u> | | | |
| | | | Bowie, Maryland | | | | | | |

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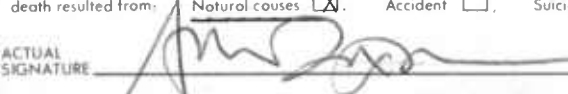
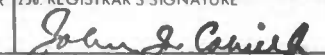
10-10-52

10-10-52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|---|--|---|---------------------------------------|---|--|---|--------------------------|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MICHAEL Brandon SHIPLEY | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10 14 1983 | | 2b. HOUR 7:42 a m | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR Aug. 8, 1983 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 0 | IF UNDER 1 YR.
MONTHS DAYS 3 | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD 10 14 1983 | | 2d. HOUR 7:42 a m | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS
107 Temple Dr. 21122 | | | | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Anne Arundel Pasadena | | 13c. STREET ADDRESS
107 Temple Dr. 21122 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Kelly | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sherry Shipley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
James Shipley | | ADDRESS
same as 13 e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
7980
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
10-15-83 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10-17-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mc Cully Funeral Home 3204 Mountain Rd. 21122 | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 18 1983 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

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011071958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after date with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 28512 EDT

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JOHN J SHIROKY | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 29, 1983 | | 2b. HOUR
525 AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
5-17-94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
FIRE PREVENTION - CHEM. CO. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
SEVERNA PK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOSEPH SHIROKY | | 15. MOTHER'S M maiden name FIRST MIDDLE LAST
UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
212 20 4064 | |
| 17. INFORMANT
AGNES J. SHIROKY - ABOVE | | 18. ADDRESS
21146 | | 19. STREET ADDRESS / ZIP CODE
135 TRUCKHOUSE RD 21146 | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Recurrent Aspiration pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent Stroke</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21g. I certify that (I) (this hospital) attended the deceased from 10-19-83 to 10-29-83, that (I) (we) last saw the deceased alive on 10-29-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22a. SIGNATURE
DALITT S. SAWINEY, M.D. | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. ADDRESS
7422 BALTIMORE-ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | 22d. DATE SIGNED
10/29/83 | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
10-31-83 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
GLEN BURNIE, MARYLAND A.A. Md. | |
| 24. FUNERAL DIRECTOR
Paul J. Banas, Severna Park | | 24a. ADDRESS
Severna Park | | 24b. DATE REC'D. BY REGISTRAR
NOV 04 1983 | | 24c. REGISTRAR'S SIGNATURE
John J. Carver | |

MEDICAL CERTIFICATION



2

• 11.4. VBA2002 24.11.1995

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 1 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (A.K.A.) Wilmore
(TYPE OR PRINT) CHARLES WILMER | | Barto
SMITH | | 2a. DATE OF DEATH MONTH DAY YEAR
October 3, 1983 | | 2b. HOUR
M | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
April 4, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Furniture | |
| 13a. STATE
Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles W. Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Ann Barto | | 13e. STREET ADDRESS / ZIP CODE
Apt. C2 21061
6906 Glen Ridge Circle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. II 162-12-7312 | | 17 INFORMANT (Daughter) ADDRESS
Miss. Denise M. Snyder Same as # 13 | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) A. murmur.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ashok Chatterjee | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Ashok Chatterjee | | | | 22e. ADDRESS
3927 Annapolis Road
Baltimore, Md. 21227 | | | |

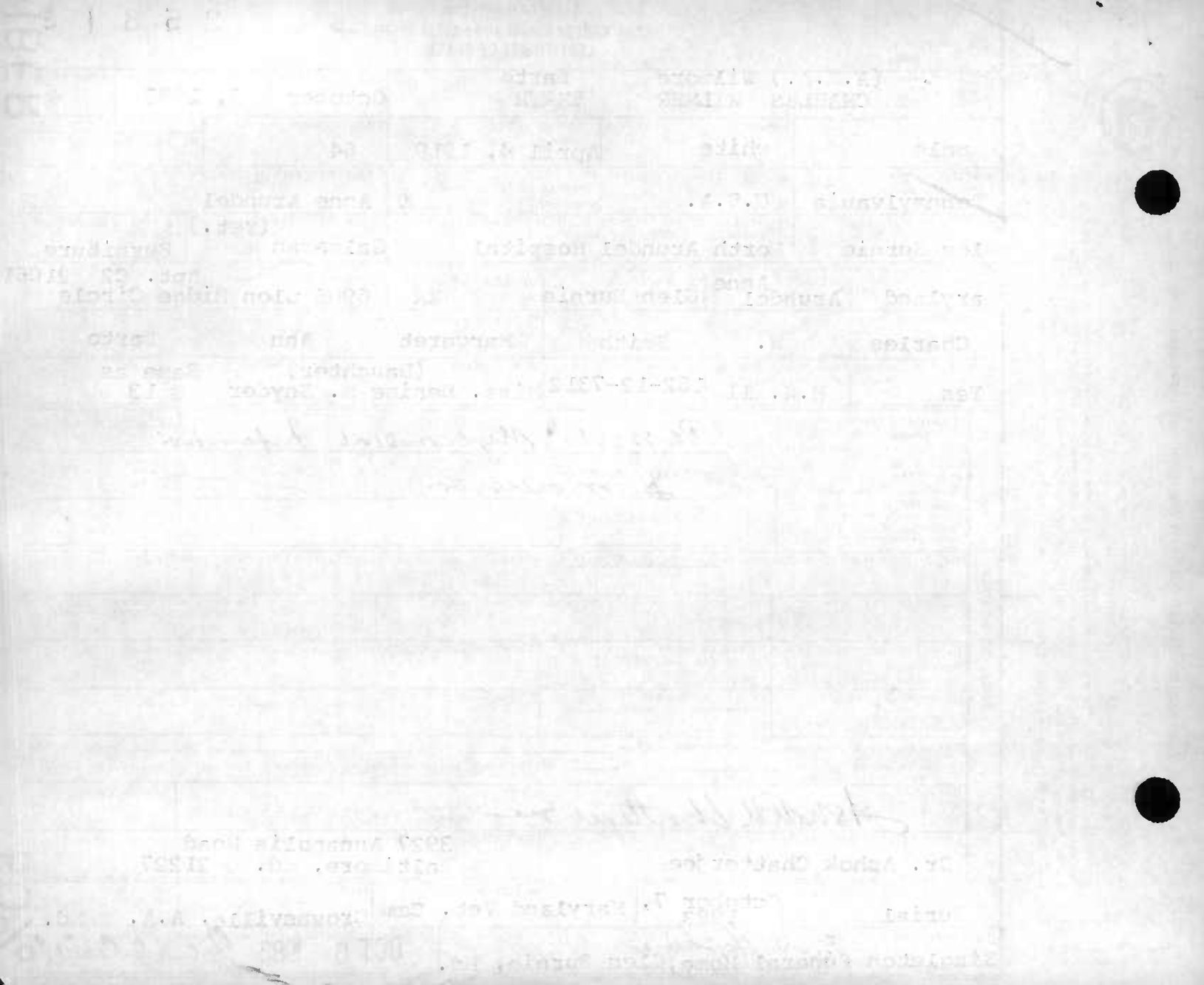
| | | | | | | | |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
October 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Vet. Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville, A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME
R. H. Hopkins | | | | 25a. DATE RECEIVED BY REGISTRAR
OCT 6 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |
| Singleton Funeral Home, Glen Burnie, Md. | | | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN SMITH | | 2a. DATE OF DEATH MONTH DAY YEAR 10-29-83 | | 2b. HOUR 5:30p |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR 7 29 23 | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE
MARYLAND | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
ANNAPOLIS |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY GROSS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HESTER BROWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
ADDRESS
Annapolis, Md. 21403 | | ALBERT SMITH 1162 Eastport Terrace | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Malnutrition, generalized metastases | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-13 19 83 , to 10-29 19 83 , that (I) (we) last saw the deceased alive on 10-29 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. | | | | |
| 22b. SIGNATURE
Evelyn A. Hill | | 22c. DATE SIGNED
10/30/83 | | 22d. ADDRESS
20 Ridgely Ave. Anne. Md. 21401 |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Evelyn A. Hill | | 22f. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
11-3-1983 | 23c. NAME OF CEMETERY OR CREMATORY
BREWER HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
NOV 1 1983 John J. Calkins | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



Handwritten notes and stamps at the top of the page, including a date stamp "JAN 19 1964" and various illegible markings.

Handwritten signature or name in the middle section.

Handwritten text or signature below the middle section.

Handwritten notes and signatures at the bottom of the page, including a date "1/20/64".

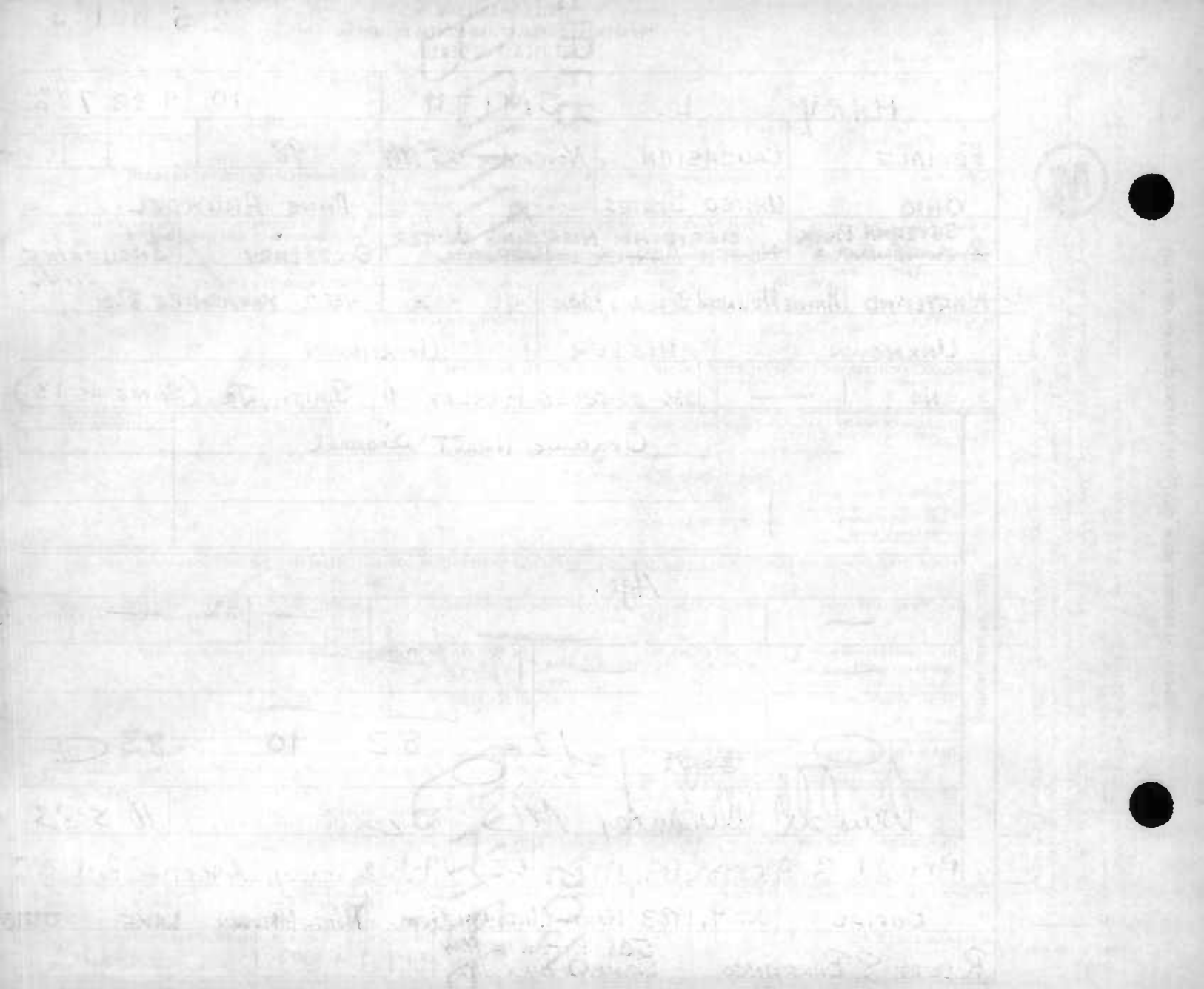
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY L. SMITH | | | | 2a. DATE OF DEATH
MONTH 10 DAY 4 YEAR 83 7 4 PM | | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH NOVEMBER DAY 25 YEAR 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
98 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD | | | | | |
| 10. CITY OR TOWN OF DEATH
SEVERNA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NAMED IN ITEM 10, PRINT NAME)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | | | 12b. KIND OF BUSINESS OR INDUSTRY
INSURANCE | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
452 YORKSHIRE DR. 21146 | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE LAST HIELER | | | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
286-30-00438 | | 17. INFORMANT
ADDRESS HARLEY A. SMITH, JR. (SAME AS 13) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Organic Heart Disease
4299
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Age. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19
P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 to 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE
Arnold G. Alexander MD | | | | | | | | | | 22c. DATE SIGNED
10-5-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arnold G. Alexander, M.D. | | | | 22e. ADDRESS
650 Ritchie Hwy, Severna Park, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
OCT. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
NORTH MADISON CEM. | | | | 23d. LOCATION
CITY OR TOWN NORTH MADISON COUNTY LAKE STATE OHIO | | | |
| 24. FUNERAL DIRECTOR
NAME ROBERT S. BARRANCO | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 11 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

| | | | | | |
|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| EMILY JANE SNYDER | | OCTOBER 23, 1983 | | 650 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | White | MONTH DAY YEAR
Feb. 15, 1893 | | 90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | U.S.A. | | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Housewife | | at home |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| Md. | Anne Arundel | P. sadena | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | (YES/NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| | | Craig Sarah | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 214-20-4985 | | Ann Kane same as 13 e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute @ ventricular failure</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Acute inferior M.I.</u>
(b) <u>@ middle cerebral thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Bronchopneumonia</u>
(c) <u>4850</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10-3-83</u>
<u>10-5-83</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| none | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | N/A. | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 2</u> 19 <u>83</u> , to <u>Oct 23</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Oct. 23</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Benjamin A. de Guzman, M.D. | | M.D. | | 10/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | |
| BENJAMIN A. DE GUZMAN, M.D. | | 325 HOSPITAL DRIVE, SUITE 108
GLEN BURNIE, MARYLAND 21061 | | John J. Connel | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 10-26-83 | | LOU DON PRK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| BALTIMORE CITY MD | | OCT 25 1983 | | John J. Connel | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | |
| McCULLY FUNERAL HOME 3204 MOUNTAIN RD | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Form 100-1
U.S. A.
North Carolina
at home
2120
24-30-1987
has been seen in 13 e

Handwritten notes and signatures at the bottom of the page.

BOX: COTTON
CHIEF



Handwritten notes and signatures at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Bessie L. Soper | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Oct. 14 1983 | | | 2b. HOUR
4:15 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 22 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jess Thompson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisy | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO N/A | | | |
| 16b. SOCIAL SECURITY NO.
578-20-0528A | | 17. INFORMANT
ADDRESS
JoAnn Quattrocchi Same as 13c | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4289
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
4 year |
|---|--|---|

| | | | |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/27/81</u> , 19 <u>83</u> , to <u>10/14/83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
DEGREE
Robert McCeney M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert McCeney Md.. | | 22e. ADDRESS
402 Main Street Laurel, Maryland | |

| | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
17 Oct. 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | |
| 24. FUNERAL DIRECTOR
NAME
FLECK FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 19 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 1 8

REG. NO.

EDT

| | | | | | | | | | | |
|---|--|---|---|---|-----------------------------------|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ISAAC Stevenson SPONAUGLE | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 19, 1983 | | 2b. HOUR
930 PM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 30, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
61 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Towmotor Driver Containers | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Brooklyn PK. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
5312 Brookwood Road 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles W. Sponaugle | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bessie Arbogast | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | |
| 16b. SOCIAL SECURITY NO.
W.W. II 234.26.0923 | | | 17. INFORMANT
Atha Mae Sponaugle (wife) | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PANCREATIC CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Fred Kahn M.D. | | | | 22c. DATE SIGNED | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRED T. KAHN, M.D. | | |
| 22e. ADDRESS
7575 RITCHIE HIGHWAY, S. E. GLEN BURNIE, MARYLAND 21061 | | | | 22f. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Oct. 22, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Brooklyn Pk. A.A. MD | | | | |
| 24. FUNERAL DIRECTOR NAME
Singleton Funeral Home Glen Burnie, MD | | | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
OCT 25 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canick | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or office.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Andrew Edward Strohmmer</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>October 13, 1983</i> | | | 2b. HOUR
M
<i>AM</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>June 25, 1907</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>76</i> YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Glen Burnie</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>1757 Marley Ave. 21061</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Grain Elevator</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>V. Md. R.R.</i> | | |
| 13a. STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Anne Arundel</i> | | 13c. CITY OR TOWN
<i>Glen Burnie</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>John Strohmmer</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Unk. Unk.</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OF DATES)
<i>N/A</i> | | 17. INFORMANT
ADDRESS
<i>Frances Strohmmer same as 13 e</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>
<i>4960</i>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>Severe Chronic Obstructive Airway</i>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <i>Pneumonia with Coe Pulmonale</i> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>John J. Presbitero, M.D.</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>10/15/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Presbitero</i> | | | | 22e. ADDRESS
<i>Oakwood Rd.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>10-17-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cent</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore Md.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>McCully Funeral Home 3204 Mountain Rd. 21122</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 18 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Conner</i> | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 3 2 5 8 2 0 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| 2b. HOUR | | | | | | | |
| 3. SEX | | | | 4. RACE | | | |
| 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS / ZIP CODE | | | | 13f. STREET ADDRESS / ZIP CODE | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT | | | | 17. ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 9</u> , 19 <u>83</u> , to <u>OCT 8</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>OCT 8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Otto B Swanner | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Oct. 28 1983 | | | 2b. HOUR
8¹ A M | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 29, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Norfolk Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A.Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Crofton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1713 Tarleton Way | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Sales | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS
1713 Tarleton Way | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Crofton | | 13d. STREET ADDRESS
1713 Tarleton Way | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Ophas Swanner | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Waters | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
Pamela Swanner | | ADDRESS
1713 Tarleton Way Crofton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4148 cardiac arrest
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) arrhythmia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) ischemic cardiomyopathy | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 min.
4 min. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 83 , to 10/27 , 19 83 , that (I) (we) lost saw the deceased alive on 10/21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Stuart E. Selowich, M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
10/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart E. Selowich, M.D. | | | | | 22e. ADDRESS
51 Franklin St. Annapolis Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10/31/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veterans Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cronsville, Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hardesty Funeral Home 12 Ridgely Ave. Ann. Md. | | | | | 25. DATE REC'D. BY REGISTRAR
NOV 1 1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

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THE UNIVERSITY OF CHICAGO
LIBRARY



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CHICAGO



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

EDT

| | | | | | | | |
|---|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LENA Catherine TANNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 11, 1983 | | 2b. HOUR
9:32 A | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 16, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter E. Gilbert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Tracey | | 13e. STREET ADDRESS
#4 Forest Rd. | | 21061 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
212-09-9385 | | 17. INFORMANT
Charles E. Tanner (son) | | ADDRESS
Laurel, MD 29708 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Boats
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)
Severe Chronic Obstructive Lung Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-9-83 to 10-11-83 , that (I) (we) lost saw the deceased alive on 10-11-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
MD | | 22c. DATE SIGNED
10-11-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK I. STERN, M.D. | | | | 22e. ADDRESS
300 Hospital Dr. #135
Glen Burnie, Md. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Oct. 14, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | | ADDRESS
Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR
OCT 13 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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OCTOBER 11, 1953

TANNER

CATHERINE

LENA

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ANNE ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

GLENN BURNIE

1000

1953

1953

1953

100 Hospital Dr. #152
Glen Burnie, Md. 21038

JACK I. STERN, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

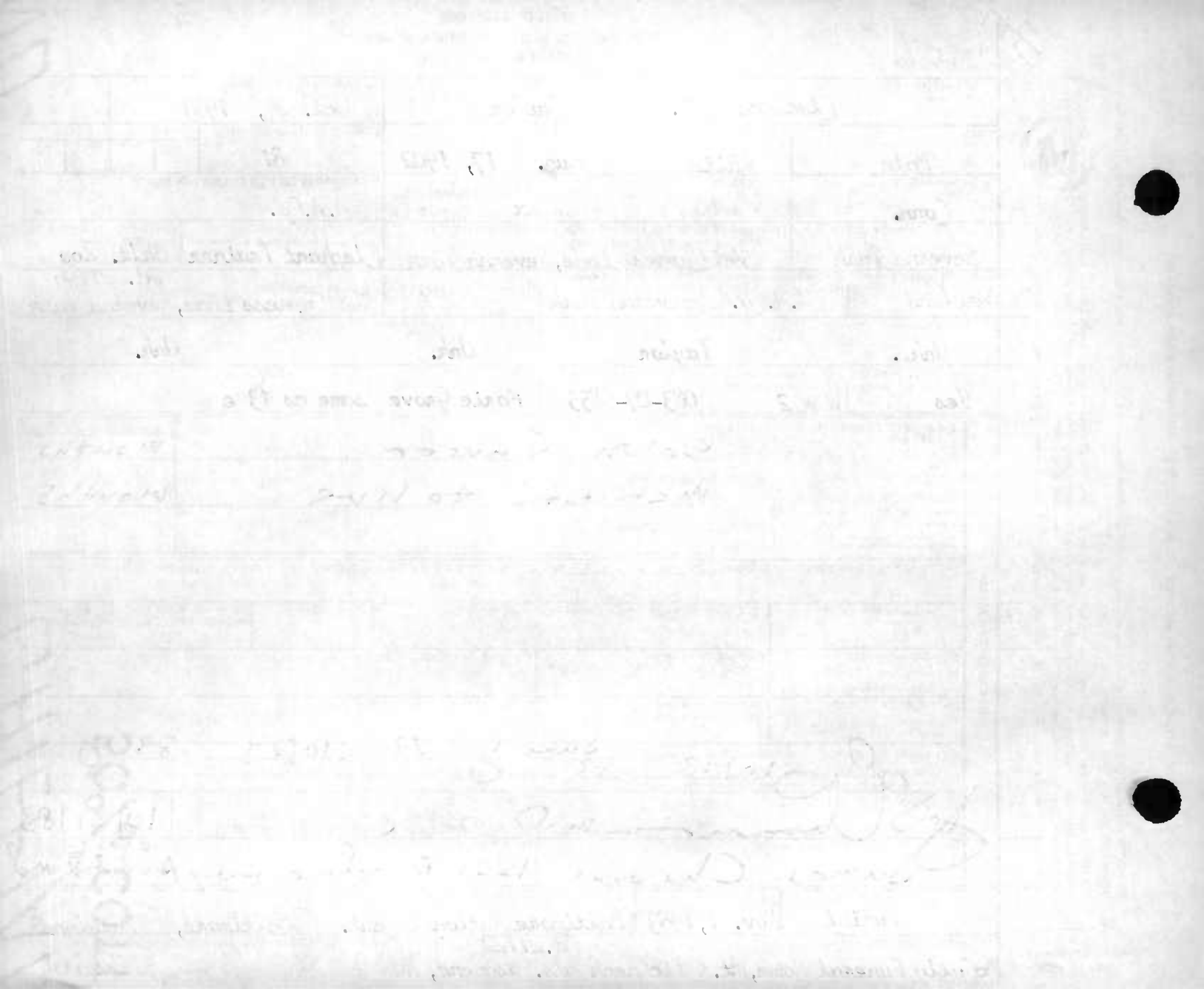
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Clarence E. Taylor</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>Oct. 29, 1983</i> | | 2b. HOUR
M |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Aug. 17, 1902</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>81</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Conn.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>A.A.Co.</i> MD | |
| 10. CITY OR TOWN OF DEATH
<i>Severna Park</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>548 Cypress Lane, Severna Park</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Elephant Trainer</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Balt. Zoo</i> | |
| 13a. STATE
<i>Md.</i> | 13b. COUNTY
<i>A.A.Co.</i> | 13c. CITY OR TOWN
<i>Severna Park</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
<i>548 Cypress Lane, Severna Park</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Unk., Taylor</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Unk.</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>WW 2 083-09-6855</i> | | 17. INFORMANT ADDRESS
<i>Marie Grove same as 13 e</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Colon Cancer</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic to liver</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1539 Months</i>
<i>Months</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1979</i> to <i>10/29, 1983</i> , that (I) (we) lost
saw the deceased alive on <i>10/13, 1983</i> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>James Chaconas</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>10/31/83</i> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | 23b. DATE
<i>Nov. 1, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Baltimore National Cent.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>McGully Funeral Home, Mt. & Tickneck Rds. Pasadena, Md. 21122</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>NOV 2 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Casier</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Sodonia Marian Taylor</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>10/10/83</u> | | | |
| 3. SEX <u>F</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>1 25 1892</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>91</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Harwood</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Katie Brashears Nursing Care</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Wt. Family</u> | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>A.A.</u> | | 13c. CITY OR TOWN <u>Annapolis</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Elias Parker</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Harriett Thomas</u> | | 16. SOCIAL SECURITY NO. <u>553-48-4093</u> | | | |
| 17. INFORMANT <u>Eleanor B. Reese</u> | | ADDRESS <u>821 West St. Annapolis, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) <u>Coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>20 years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Chronic renal failure.</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 9, 1983</u> to <u>October 10, 1983</u> , that (I) (we) last saw the deceased alive on <u>October 6, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Richard E. Cook, M.D.</u> | | | | DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>10/10/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>113 Cathedral Street Annapolis, Md.</u> | | | | 22e. ADDRESS <u>21401 Richard E. Cook, M.D.</u> | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | 23b. DATE <u>10/12/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis A.A. Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>William Keese</u> ADDRESS <u>Sons-821 West St. Annapolis, Md.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>OCT 11 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>Sam J. Gough</u> | |

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1. Maatregelen die te nemen zijn:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|---|-------------|--|------------------------|---|---|--|-------|--|------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| WILLIAM H. TAYLOR Jr. | | | | | OCTOBER | 17 | 1983 | | | 1200 A.M. | |
| 3. SEX | male | 4. RACE | white | | 5. DATE OF BIRTH | July 14, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) | 63 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MD | 7b. CITIZEN OF WHAT COUNTRY? | USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | steelworker | | 12b. KIND OF BUSINESS OR INDUSTRY | Acme Steel | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | 318 Gatewater Ct. (21061) | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | FIRST | MIDDLE | LAST | | |
| William H. Taylor Sr. | | | | | Mary Ann Helmick | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE NUMBER) | | 17. INFORMANT | | ADDRESS same as 13 | | | | | |
| | | WW 11 216/07/1555 | | Charles D. Hayes (Son in law) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 minutes | |
| 1539 } DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic carcinoma of the colon | | | | | | | | | | 7 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
{ DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15, 1983, to 10/17, 1983, that (I) saw the deceased alive on 10/16, 1983, and that in (my) opinion death occurred on the date and hour and from the causes stated above; (if true) (did/did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John F. Kressler, M.D.</i>
DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
10/17/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN F. KRESSLER, M.D. | | | | 22e. ADDRESS
7445-A FURNACE BRANCH ROAD
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE) Cremation | | 23b. DATE
17 Oct. 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process Inc Catonsville, Balt., MD | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME Dean P. Chertea ADDRESS Singleton Funeral Home, Glen Burnie, MD | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 18 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

11/10

1. The first part of the report is a general description of the project and its objectives. This section is intended to provide a brief overview of the work that has been done and to set the context for the more detailed results that follow.

2. The second part of the report is a description of the methods used in the study. This section is intended to provide a detailed account of the procedures and techniques that were used to collect and analyze the data.

3. The third part of the report is a description of the results of the study. This section is intended to provide a detailed account of the findings of the study and to discuss the implications of these findings for the field of research.

4. The fourth part of the report is a discussion of the conclusions that can be drawn from the study. This section is intended to provide a summary of the main findings of the study and to discuss the limitations of the study and the need for further research.

5. The fifth part of the report is a list of references. This section is intended to provide a list of the sources of information that were used in the study.

6. The sixth part of the report is a list of figures. This section is intended to provide a list of the figures that are included in the report.

7. The seventh part of the report is a list of tables. This section is intended to provide a list of the tables that are included in the report.

8. The eighth part of the report is a list of appendices. This section is intended to provide a list of the appendices that are included in the report.

9. The ninth part of the report is a list of acknowledgments. This section is intended to provide a list of the people and organizations that have provided support for the study.

10. The tenth part of the report is a list of footnotes. This section is intended to provide a list of the footnotes that are included in the report.

11. The eleventh part of the report is a list of references. This section is intended to provide a list of the sources of information that were used in the study.

12. The twelfth part of the report is a list of figures. This section is intended to provide a list of the figures that are included in the report.

13. The thirteenth part of the report is a list of tables. This section is intended to provide a list of the tables that are included in the report.

14. The fourteenth part of the report is a list of appendices. This section is intended to provide a list of the appendices that are included in the report.

#8 FOR 15. Film G585 11/3/83 kam

1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 3 2 5 8 2 6

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mildred L Thomas | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10 20 83 | | 2b. HOUR
238 AM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
8 8 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATE | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, / ZIP CODE
317 SOUTH PARRISH ST. 21223 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN WESLEY FERGUSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
LOUISA FAULKNER | | ADDRESS
1030 ARUNDEL DR. P.O. Box 21 ARNOLD, MD. 21012 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
214-50-7703 | | 17. INFORMANT
MILDRED L. KING | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Obstructive Lung Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Alcoholism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/12 , 19 83 , to 10/20 , 19 83 , that (I) (we) saw the deceased alive on 10/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
R. I. Hochman, MD | | DEGREE
MD | | 22c. DATE SIGNED
10/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard I. Hochman, MD | | 22e. ADDRESS
16 Murray Ave, Annapolis, Md. 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
OCT. 24, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
ASBURY UNITED METHODIST CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARNOLD ANNE ARUNDEL MD. | |
| 24. FUNERAL DIRECTOR
NAME
Barranco Severa | | ADDRESS
Park F.H. | | 25a. DATE REC'D. BY REGISTRAR
OCT. 24 1983 | 25b. REGISTRAR'S SIGNATURE
John J. Conner |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REPER

CONFIDENTIAL

10 20 30 40 50 60 70 80 90 100
WHITE 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

10 20 30 40 50 60 70 80 90 100

10 20 30 40 50 60 70 80 90 100

10 20 30 40 50 60 70 80 90 100

10 20 30 40 50 60 70 80 90 100

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William Henry Thomas | | | 2a. DATE OF DEATH MONTH DAY YEAR
10/23/83 | | | 2b. HOUR
M | |
| 3. SEX
M | | 4. RACE
Negro | | 5. DATE OF BIRTH MONTH DAY YEAR
MAR 21 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A. A. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
906-E Royal ST | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Warehouse | | 12b. KIND OF BUSINESS OR INDUSTRY
Lohr Grocery | |
| 13a. STATE
md | | 13b. COUNTY
A. A. | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Henry Thomas | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.II | |
| 17. INFORMANT
ADDRESS
ANNAPOLIS, md | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>atherosclerotic cardiovascular disease</u>
4149
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic congestive heart failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
B. T. Furlow | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Oct 25, 83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. T. Furlow | | 22e. ADDRESS
77 West St. Suite 210 Annapolis Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10-28-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
md NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAWRENCE P.G. md | |
| 24. FUNERAL DIRECTOR
NAME
C.E. Hicks | | 24b. DATE
1922 Forest Drive | | 24c. ADDRESS
ANNAPOLIS | | 25a. DATE REC'D. BY REGISTRAR
OCT 26 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE
Joan J. Conner | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|-----------------------------------|---|--|---------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 10 30 83 | | | 1 37 AM |
| CATHERINE B. TOBIN | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | | |
| FEMALE | WHITE | MONTH DAY YEAR | 42 YRS. | | | | | |
| 1 18 41 | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PA | U.S.A. | Anne Arundel Co. MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Annapolis | Anne Arundel Gen. | | Secretary | | College | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | | | |
| MD | AA | Amor | 1256 Dogwood Rd. 21012 | | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | | | | |
| Charles Butler | Frances Gates Butler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | | | | |
| No | 188-32-0107 | John F. Tobin - Above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | 2 YRS | |
| IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | 9/26 | | 10/30 83 | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/29 19 83, to 10/30 19 83, that (1) (we) lost saw the deceased alive on 10/29 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| E. W. COLE III | | MD | | | | 10/30/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | |
| E. W. COLE | | 51 FRANKLIN ST ANNAPOLIS Md. | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | 11/2/83 | Hollywood Cem | | Annapolis AA Md. | | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | REGISTRAR'S SIGNATURE | | | | |
| Charles Lawrence | | NOV 04 1983 | | John J. Connel | | | | |

BP

11

| NAME | | ADDRESS | | CITY | | STATE | | ZIP | |
|------|-----------|---------|-----------|---------------|---------|-------|-------|-----|-----|
| 1 | JOHN | 123 | ST | NEW | YORK | NY | 10001 | 100 | 100 |
| 2 | JANE | 456 | AVENUE | LOS | ANGELES | CA | 90001 | 200 | 200 |
| 3 | BOB | 789 | BLVD | CHICAGO | ILL | 60601 | 300 | 300 | 300 |
| 4 | ALICE | 101 | DR | HOUSTON | TX | 77001 | 400 | 400 | 400 |
| 5 | CHARLIE | 202 | WAY | PHOENIX | AZ | 85001 | 500 | 500 | 500 |
| 6 | DAN | 303 | COURT | SEATTLE | WA | 98101 | 600 | 600 | 600 |
| 7 | EVE | 404 | LANE | PORTLAND | OR | 97201 | 700 | 700 | 700 |
| 8 | FRANK | 505 | TRAIL | SAN FRANCISCO | CA | 94101 | 800 | 800 | 800 |
| 9 | GRACE | 606 | ALLEY | OAKLAND | CA | 94601 | 900 | 900 | 900 |
| 10 | HELEN | 707 | BOULEVARD | BALTIMORE | MD | 21201 | 000 | 000 | 000 |
| 11 | IRVING | 808 | PIKE | BOSTON | MA | 02101 | 100 | 100 | 100 |
| 12 | JACK | 909 | DRIVE | NEWARK | NJ | 07101 | 200 | 200 | 200 |
| 13 | JILL | 010 | STREET | INDIANAPOLIS | IN | 46201 | 300 | 300 | 300 |
| 14 | KEN | 111 | AVENUE | COLUMBIA | SC | 29201 | 400 | 400 | 400 |
| 15 | LUCAS | 222 | BLVD | MEMPHIS | TN | 38101 | 500 | 500 | 500 |
| 16 | MARY | 333 | WAY | ATLANTA | GA | 30301 | 600 | 600 | 600 |
| 17 | NED | 444 | COURT | DAVIDSON | NC | 28013 | 700 | 700 | 700 |
| 18 | OLIVIA | 555 | LANE | CHARLOTTE | NC | 28201 | 800 | 800 | 800 |
| 19 | PETER | 666 | TRAIL | CONCORD | NC | 28027 | 900 | 900 | 900 |
| 20 | QUINN | 777 | PIKE | GREENSBORO | NC | 27401 | 000 | 000 | 000 |
| 21 | RALPH | 888 | DRIVE | WILMINGTON | DE | 19801 | 100 | 100 | 100 |
| 22 | SARAH | 999 | STREET | DOVER | DE | 19901 | 200 | 200 | 200 |
| 23 | TOM | 000 | AVENUE | WILMINGTON | DE | 19801 | 300 | 300 | 300 |
| 24 | URSULA | 111 | BLVD | DOVER | DE | 19901 | 400 | 400 | 400 |
| 25 | VICTOR | 222 | WAY | GREENSBORO | NC | 27401 | 500 | 500 | 500 |
| 26 | WILLIAM | 333 | COURT | CONCORD | NC | 28027 | 600 | 600 | 600 |
| 27 | XENIA | 444 | LANE | DAVIDSON | NC | 28013 | 700 | 700 | 700 |
| 28 | YVES | 555 | TRAIL | CHARLOTTE | NC | 28201 | 800 | 800 | 800 |
| 29 | ZACHARY | 666 | PIKE | WILMINGTON | DE | 19801 | 900 | 900 | 900 |
| 30 | ADAM | 777 | DRIVE | DOVER | DE | 19901 | 000 | 000 | 000 |
| 31 | BELLA | 888 | STREET | WILMINGTON | DE | 19801 | 100 | 100 | 100 |
| 32 | CARL | 999 | AVENUE | DOVER | DE | 19901 | 200 | 200 | 200 |
| 33 | DORA | 000 | BLVD | GREENSBORO | NC | 27401 | 300 | 300 | 300 |
| 34 | ERNEST | 111 | WAY | CONCORD | NC | 28027 | 400 | 400 | 400 |
| 35 | FLORENCE | 222 | COURT | DAVIDSON | NC | 28013 | 500 | 500 | 500 |
| 36 | GEOFFREY | 333 | LANE | CHARLOTTE | NC | 28201 | 600 | 600 | 600 |
| 37 | HENRIETTA | 444 | TRAIL | WILMINGTON | DE | 19801 | 700 | 700 | 700 |
| 38 | IGOR | 555 | PIKE | DOVER | DE | 19901 | 800 | 800 | 800 |
| 39 | JANET | 666 | DRIVE | WILMINGTON | DE | 19801 | 900 | 900 | 900 |
| 40 | KENNETH | 777 | STREET | DOVER | DE | 19901 | 000 | 000 | 000 |
| 41 | LUCILLE | 888 | AVENUE | GREENSBORO | NC | 27401 | 100 | 100 | 100 |
| 42 | MARTIN | 999 | BLVD | CONCORD | NC | 28027 | 200 | 200 | 200 |
| 43 | NANCY | 000 | WAY | DAVIDSON | NC | 28013 | 300 | 300 | 300 |
| 44 | OSCAR | 111 | COURT | CHARLOTTE | NC | 28201 | 400 | 400 | 400 |
| 45 | PATRICIA | 222 | LANE | WILMINGTON | DE | 19801 | 500 | 500 | 500 |
| 46 | ROBERT | 333 | TRAIL | DOVER | DE | 19901 | 600 | 600 | 600 |
| 47 | SANDRA | 444 | PIKE | WILMINGTON | DE | 19801 | 700 | 700 | 700 |
| 48 | TIMOTHY | 555 | DRIVE | DOVER | DE | 19901 | 800 | 800 | 800 |
| 49 | URSULA | 666 | STREET | WILMINGTON | DE | 19801 | 900 | 900 | 900 |
| 50 | VICTOR | 777 | AVENUE | DOVER | DE | 19901 | 000 | 000 | 000 |
| 51 | WILLIAM | 888 | BLVD | GREENSBORO | NC | 27401 | 100 | 100 | 100 |
| 52 | XENIA | 999 | WAY | CONCORD | NC | 28027 | 200 | 200 | 200 |
| 53 | YVES | 000 | COURT | DAVIDSON | NC | 28013 | 300 | 300 | 300 |
| 54 | ZACHARY | 111 | LANE | CHARLOTTE | NC | 28201 | 400 | 400 | 400 |
| 55 | ADAM | 222 | TRAIL | WILMINGTON | DE | 19801 | 500 | 500 | 500 |
| 56 | BELLA | 333 | PIKE | DOVER | DE | 19901 | 600 | 600 | 600 |
| 57 | CARL | 444 | DRIVE | WILMINGTON | DE | 19801 | 700 | 700 | 700 |
| 58 | DORA | 555 | STREET | DOVER | DE | 19901 | 800 | 800 | 800 |
| 59 | ERNEST | 666 | AVENUE | GREENSBORO | NC | 27401 | 900 | 900 | 900 |
| 60 | FLORENCE | 777 | BLVD | CONCORD | NC | 28027 | 000 | 000 | 000 |
| 61 | GEOFFREY | 888 | WAY | DAVIDSON | NC | 28013 | 100 | 100 | 100 |
| 62 | HENRIETTA | 999 | COURT | CHARLOTTE | NC | 28201 | 200 | 200 | 200 |
| 63 | IGOR | 000 | LANE | WILMINGTON | DE | 19801 | 300 | 300 | 300 |
| 64 | JANET | 111 | TRAIL | DOVER | DE | 19901 | 400 | 400 | 400 |
| 65 | KENNETH | 222 | PIKE | WILMINGTON | DE | 19801 | 500 | 500 | 500 |
| 66 | LUCILLE | 333 | DRIVE | DOVER | DE | 19901 | 600 | 600 | 600 |
| 67 | MARTIN | 444 | STREET | WILMINGTON | DE | 19801 | 700 | 700 | 700 |
| 68 | NANCY | 555 | AVENUE | DOVER | DE | 19901 | 800 | 800 | 800 |
| 69 | OSCAR | 666 | BLVD | GREENSBORO | NC | 27401 | 900 | 900 | 900 |
| 70 | PATRICIA | 777 | WAY | CONCORD | NC | 28027 | 000 | 000 | 000 |
| 71 | ROBERT | 888 | COURT | DAVIDSON | NC | 28013 | 100 | 100 | 100 |
| 72 | SANDRA | 999 | LANE | CHARLOTTE | NC | 28201 | 200 | 200 | 200 |
| 73 | TIMOTHY | 000 | TRAIL | WILMINGTON | DE | 19801 | 300 | 300 | 300 |
| 74 | URSULA | 111 | PIKE | DOVER | DE | 19901 | 400 | 400 | 400 |
| 75 | VICTOR | 222 | DRIVE | WILMINGTON | DE | 19801 | 500 | 500 | 500 |
| 76 | WILLIAM | 333 | STREET | DOVER | DE | 19901 | 600 | 600 | 600 |
| 77 | XENIA | 444 | AVENUE | GREENSBORO | NC | 27401 | 700 | 700 | 700 |
| 78 | YVES | 555 | BLVD | CONCORD | NC | 28027 | 800 | 800 | 800 |
| 79 | ZACHARY | 666 | WAY | DAVIDSON | NC | 28013 | 900 | 900 | 900 |
| 80 | ADAM | 777 | COURT | CHARLOTTE | NC | 28201 | 000 | 000 | 000 |
| 81 | BELLA | 888 | LANE | WILMINGTON | DE | 19801 | 100 | 100 | 100 |
| 82 | CARL | 999 | TRAIL | DOVER | DE | 19901 | 200 | 200 | 200 |
| 83 | DORA | 000 | PIKE | WILMINGTON | DE | 19801 | 300 | 300 | 300 |
| 84 | ERNEST | 111 | DRIVE | DOVER | DE | 19901 | 400 | 400 | 400 |
| 85 | FLORENCE | 222 | STREET | WILMINGTON | DE | 19801 | 500 | 500 | 500 |
| 86 | GEOFFREY | 333 | AVENUE | DOVER | DE | 19901 | 600 | 600 | 600 |
| 87 | HENRIETTA | 444 | BLVD | GREENSBORO | NC | 27401 | 700 | 700 | 700 |
| 88 | IGOR | 555 | WAY | CONCORD | NC | 28027 | 800 | 800 | 800 |
| 89 | JANET | 666 | COURT | DAVIDSON | NC | 28013 | 900 | 900 | 900 |
| 90 | KENNETH | 777 | LANE | CHARLOTTE | NC | 28201 | 000 | 000 | 000 |
| 91 | LUCILLE | 888 | TRAIL | WILMINGTON | DE | 19801 | 100 | 100 | 100 |
| 92 | MARTIN | 999 | PIKE | DOVER | DE | 19901 | 200 | 200 | 200 |
| 93 | NANCY | 000 | DRIVE | WILMINGTON | DE | 19801 | 300 | 300 | 300 |
| 94 | OSCAR | 111 | STREET | DOVER | DE | 19901 | 400 | 400 | 400 |
| 95 | PATRICIA | 222 | AVENUE | GREENSBORO | NC | 27401 | 500 | 500 | 500 |
| 96 | ROBERT | 333 | BLVD | CONCORD | NC | 28027 | 600 | 600 | 600 |
| 97 | SANDRA | 444 | WAY | DAVIDSON | NC | 28013 | 700 | 700 | 700 |
| 98 | TIMOTHY | 555 | COURT | CHARLOTTE | NC | 28201 | 800 | 800 | 800 |
| 99 | URSULA | 666 | LANE | WILMINGTON | DE | 19801 | 900 | 900 | 900 |
| 100 | VICTOR | 777 | TRAIL | DOVER | DE | 19901 | 000 | 000 | 000 |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3

2 5 8 2 9

FOR
STATE
REGISTRAR

REG. NO.

EDT

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIE Fayette TOLSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 10, 1983 | | | 2b. HOUR
8:57 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 23, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
Book Keeping | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Linthicum | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
6501 B. & A. Blvd | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Tolson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ann Donnelly | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213.03.5332 | | 17. INFORMANT
ADDRESS
brother Ernest J. Tolson 808 Weatherbee Road 21204 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) ca of Great med lvs
DUE TO, OR AS A CONSEQUENCE OF
(c) lvs to lvs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-2 , 19 83 , to 10-10 , 19 83 , that (I) (we) last saw the deceased alive on 10-9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
SACIT EREN, M.D. | | | DEGREE | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| 22e. ADDRESS
518 CAMP MEADE RD. LINTHICUM, MD. 21090 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Oct. 11, 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process Inc. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, MD. | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | ADDRESS
Glen Burnie, MD | | | 25a. DATE REC'D. BY REGISTRAR
OCT 13 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

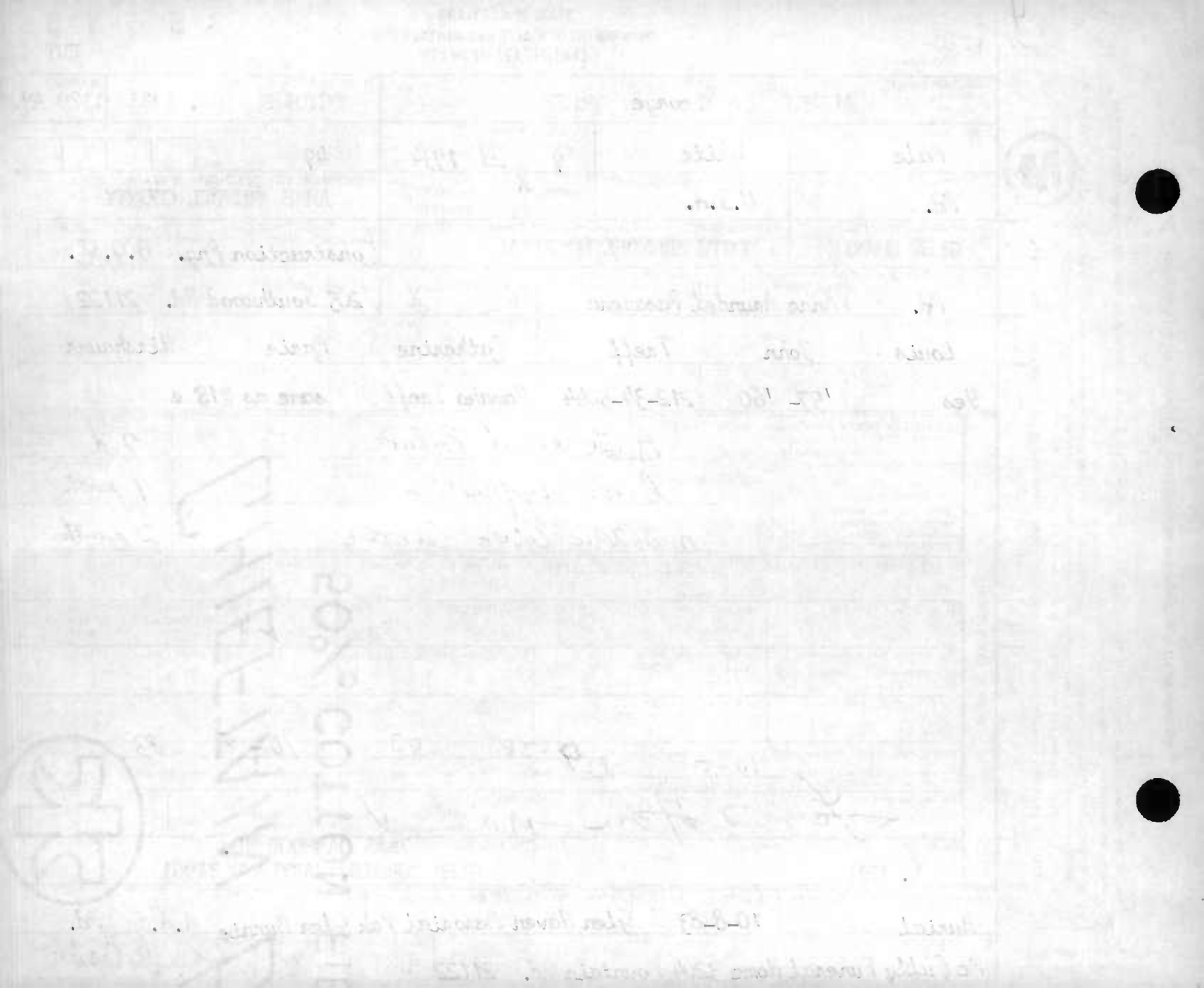
EDT

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ALBERT George TREFF | | | 2a. DATE OF DEATH MONTH DAY YEAR
OCTOBER 05, 1983 | | 2b. HOUR
1120 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
9 28 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction Eng. | | 12b. KIND OF BUSINESS OR INDUSTRY
B.G.&C. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Louis John Treff | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Catherine Marie Hinshauer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
157-160 | | 17. INFORMANT ADDRESS
Hamako Treff same as #1 e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u>
<u>1539</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Liver dysfunction</u>
(c) <u>metastatic Colon Cancer</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 d</u>
<u>1 month</u>
<u>2 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> to <u>10-5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>L. HSU</u> | | DEGREE
A.O. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. HSU | | 22e. ADDRESS
7845 OAKWOOD RD.
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
10-8-83 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. |
| 24. FUNERAL DIRECTOR
NAME
Mc Cully Funeral Home | | ADDRESS
3204 Mountain Rd. 21122 | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1983 | 25b. REGISTRAR'S SIGNATURE
<u>John J. Casier</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 3 1

FOR
STATE
REGISTRAR

REG. NO.

EDT

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
HARTLEIGH NORMAN TRENT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 2, 1983 | | 2b. HOUR
6:25 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 24, 1927 | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tenn. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Intelligence Research Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Army |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Linthicum | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dwight Trent | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada M. Trent | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
1945-1965 415-38-2653 | 17. INFORMANT
Mrs. Rose Y. Trent
712 Andover Road Linthicum, MD. 21090 | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
2000
DUE TO, OR AS A CONSEQUENCE OF
(b) Diffuse Histiocytic Lymphoma
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days
18 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Heart Disease with Atrial fibrillation | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-27 , 19 83 , to 10-2 , 19 83 , that (I) (we) lost saw the deceased alive on 10-2 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
M.D. | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LONG S. HSU, M.D. | | 22e. ADDRESS
MARYLAND 21061
7845 OAKWOOD ROAD #104, GLEN BURNIE, | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Oct. 6, 83 | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Mem. Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD. 21133 | | 25a. DATE REC'D. BY REGISTRAR
OCT 4 - 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EDT

11:22 P

OCTOBER 2, 1963

THREE

WATERBURY HOSPITAL

STATE ANATOMICAL COUNTY

WATERBURY HOSPITAL

NEW BRIDGE

1842 GARDNER ROAD #104, GLEN HURDIE, WATKINS, 21001

PHONE 2. 2111, N.E.

WATERBURY HOSPITAL

WATERBURY HOSPITAL

WATERBURY HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

FOR
1. STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH F TYLUS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
OCTOBER 22, 1983 | | 2b. HOUR
0820 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 27 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Seafood |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
AA | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Antoinette | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216 14-8473 | | 17. INFORMANT
ADDRESS
Mrs. Helen Tylus (Same as #13.) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease</u>
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 9</u> 19 <u>83</u> , to <u>Oct 22</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Oct 21</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>Oct 22, 1983</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES J. WIL, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD
GLEN BURNIE MD 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
10/22/83 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
OCT 27 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

water 200

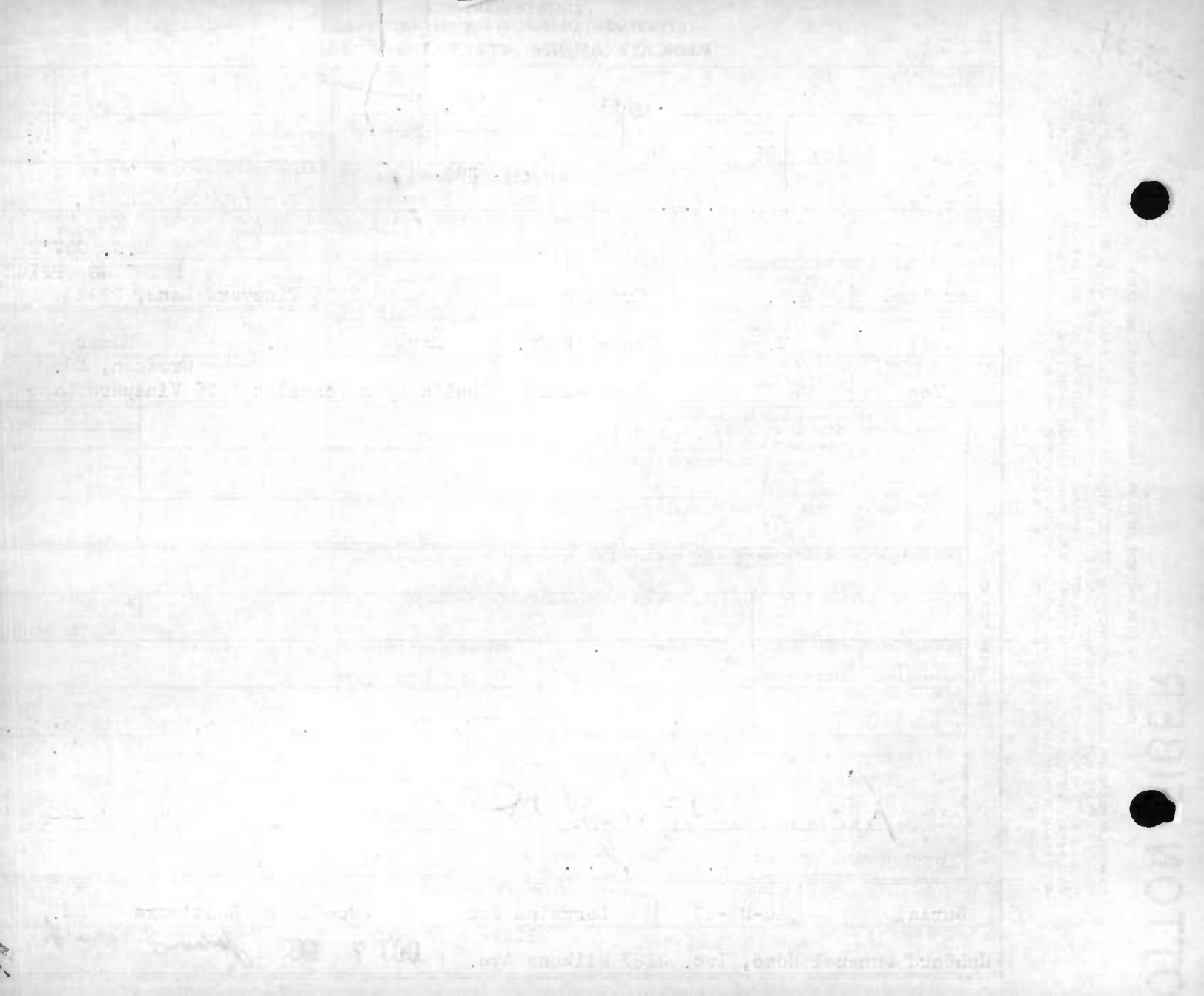
3015

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25833 | |
|--|-------------------------|---|--|--|-----------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emil Teophil Van Aelst, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> DAY YEAR 10 4 1983 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 08 30 28 | 6. AGE (IN YEARS)
LAST BIRTHDAY 55 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS | 8. IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 10 4 1983 | | 2d. HOUR
10:17 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. Leg. sep.
MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Crofton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION*
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2526 Vineyard Court | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | PRINTING OFFICE | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Crofton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2526 Vineyard Lane, 21114 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emil T. VanAelst Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. Hamer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | (IF YES, GIVE WAR OR DATES)
WW II | | 16b. SOCIAL SECURITY NO.
220-24-1516 | | 17. INFORMANT
ADDRESS Crofton, Md.
Sheila Lynn VanAelst 2526 Vineyard Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9654 Multiple Gunshot Wounds
IMMEDIATE CAUSE (a) }
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which }
gave rise to immediate }
cause (a) stating the under- }
lying cause last. }
(b) }
DUE TO, OR AS A CONSEQUENCE OF
(c) } | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 10 4 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject was shot | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2526 Vineyard Ct., Crofton, Anne Arundel Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
D. Assistant | | | | DATE SIGNED
10-5-83 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10-08-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 7 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Smith</i> | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 3 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DANIEL W. Wells | | | 2a. DATE OF DEATH
MONTH 10 DAY 8 YEAR 1983 | | | 2b. HOUR
1040 PM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 11 DAY 08 YEAR 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY)
99 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Woodwork | | | 12b. KIND OF BUSINESS OR INDUSTRY
Govt Service | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3 Hill Street 21401 | | |
| 14. FATHER'S NAME
FIRST JAMES MIDDLE N. LAST Wells | | | | 15. MOTHER'S MAIDEN NAME
FIRST SUSAN MIDDLE CRANDALL LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
27-34 6768 | | 17. INFORMANT
ADDRESS
KATHERINE W. Cohison #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
4360
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) ARTERIOSCLEROSIS, GENERALIZED
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 WKS
20 YRS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2 FEB 83 , 19 63 , to 8 OCT , 19 83 , that (1) (we) lost saw the deceased alive on 10 - 8 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward S. Beck
DEGREE
S. BECK | | | | | | 22c. DATE SIGNED
10-10-83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward S. Beck | | | | | | 22e. ADDRESS
Forest De Annapolis, M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
10/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Marys | | 23d. LOCATION
CITY OR TOWN ANNAPOLIS COUNTY AA STATE MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME Taylor Funeral Chapel ADDRESS Annapolis Md. | | | | | | 25. DECEASED'S SIGNATURE
John J. Carver | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1907

THE LAND OFFICE
OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE
THE RECEIPT OF THE
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906
AND TO TRANSMIT THE SAME
TO THE SENATE
JANUARY 10, 1907

208 COL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Agnes U Whitaker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-24-83 | | | 2b. HOUR
3:30 M | | | |
| 3. SEX
F Female | | 4. RACE
W White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5-10-03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Box 311 A Revell Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Baker Neal | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Harris | | | | 16. ADDRESS
Millersville, Md. 21101 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-03-8601 | | 17. INFORMANT
ADDRESS
Katherine F. Frye 8263 Woods Rd. | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **LEUKEMIA****2089**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/83 , 19____, to 10/24/83 , 19____, that (I) (we) lost
saw the deceased alive on 10/23/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
WATKINS | | | | 22c. ADDRESS
51 Franklin Annapolis, Md. | | 22d. DATE SIGNED
10/24/83 | |

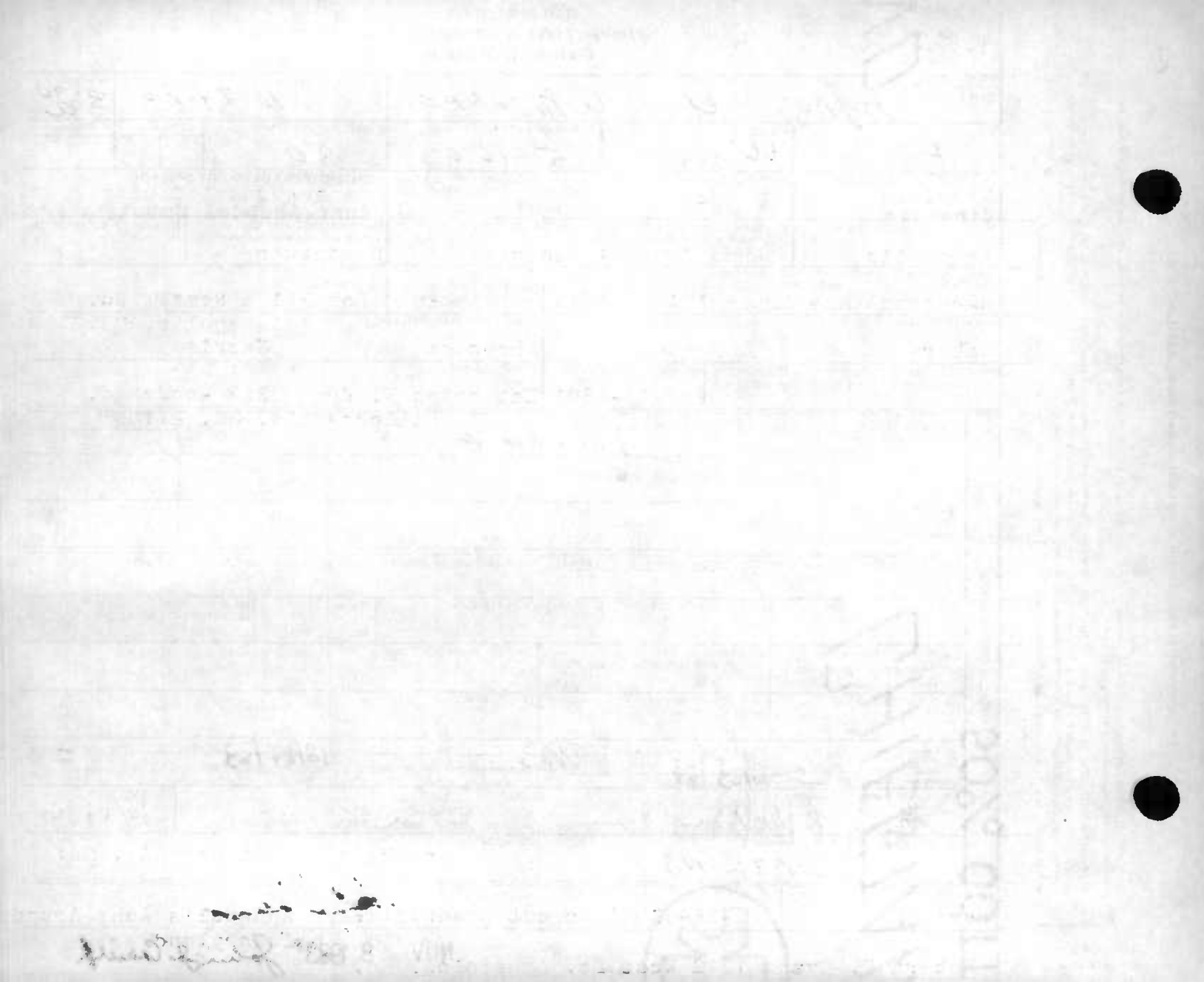
| | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
10-26-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis Anne Arundel | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert E. Evans 1212 West St. Annapolis, Md. | | | | 25. DATE REC'D. BY REGISTRAR & REGISTRAR'S SIGNATURE
NOV 8 1983 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 3 2 5 8 3 0 | | | | | |
|---|--|--|---|---|---|---|---|--|--|--|
| FOR Item#3
1 - REGISTER Film G585 11/3/83 jp | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
<i>Norma FERNA Wiles</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
<i>10-6-83 7:25 AM</i> | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>2 23 08</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>75</i> | | IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>ANNE ARUNDEL MD.</i> | | | | |
| 10. CITY OR TOWN OF DEATH
<i>ANNAPOLIS</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>ANNE ARUNDEL GENERAL HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST PREVAILING LIFE)
<i>CREDIT OFFICER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>DEPT. STORE</i> | | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>AA</i> | | 13c. CITY OR TOWN
<i>ANNAPOLIS</i> | | 13d. STREET ADDRESS
<i>21401 WHITEHALL PLAINS RD</i> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>HARRISON T. Stickell</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>— — —</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | | | | 16b. SOCIAL SECURITY NO.
<i>215-10-6466</i> | | 17. INFORMANT ADDRESS
<i>KENNETH W. WILES #13</i> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
<i>1579</i> IMMEDIATE CAUSE (a) <i>Bowel obstruction</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Pancreatic carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>—</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-5</i> , 19 <i>83</i> , to <i>10-6</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>10-6-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>A. Caputo</i> | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>10/6/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>A. CAPUTO</i> | | | | | 22e. ADDRESS
<i>132 HOLIDAY CT. ANNAPOLIS, MD.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>10/8/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Margaret's</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>ANNAPOLIS AA MD</i> | | | |
| 24. FUNERAL DIRECTOR NAME
<i>TAYLOR FUNERAL CHAPEL</i> | | | | | ADDRESS
<i>ANNAPOLIS MD.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>OCT 10 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Smith</i> | |

February 10, 1914
Mr. J. H. ...
Washington, D. C.
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. regarding the matter of the ...
Very respectfully,
[Signature]

Enclosed for you are ...
Very truly yours,
[Signature]
[Stamp: RECEIVED FEB 11 1914]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 8 3 7

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELLA M Wilkerson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
10-12-83 | | | 2b. HOUR
5:05 AM | | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 28 36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1843 Bowman Court 21401 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DENNIS JENKINS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
WILLA CREEK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
THOMAS WILKERSON 1843 Bowman Ct. Annapolis, Md. 21401 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1 year
1749 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 9/28, 1983, to 10/12, 1983, and that (2) (we) last saw the deceased alive on 10/10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE
E W Cole | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
10/12/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E W COLE | | | | 22e. ADDRESS
121 CATHEDRAL ST ANNAPOLIS Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
10-14-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Church Ceme. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lothian A.A. Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401 | | | | | | 25. DATE REC'D. BY REGISTRAR
OCT 14 1983 REGISTRAR SIGNATURE | | | | | |

MEDICAL CERTIFICATION



1

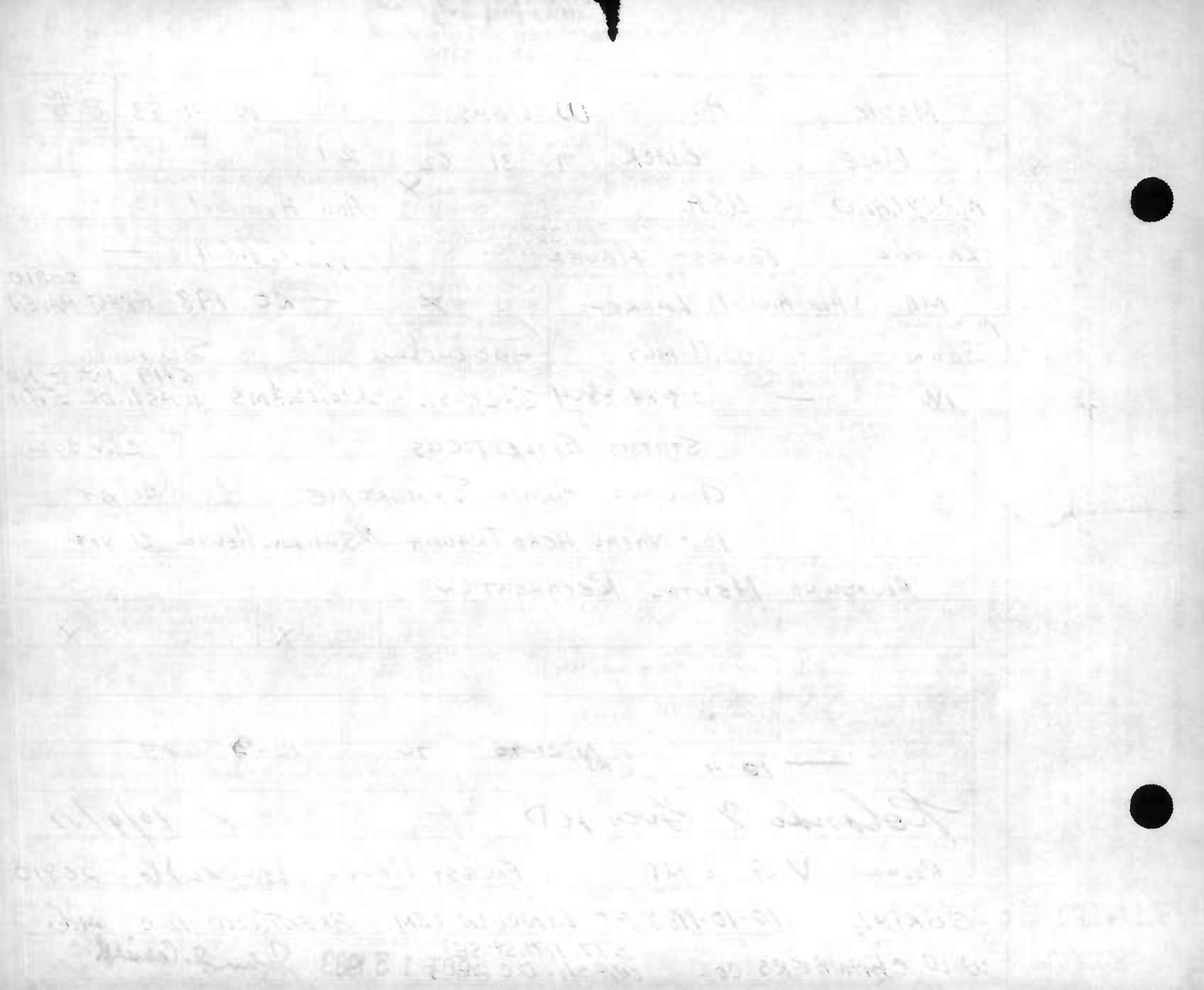
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 3 2 5 8 3 8 | | | | |
|---|-----------------|---|---|--|------------------------------------|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
MARK A. WILLIAMS | | | 2a DATE OF DEATH
MONTH DAY YEAR
10 - 4 - 83 | | | 2b HOUR
8 ⁴⁰ / ₂ M | | | |
| 3 SEX
MALE | 4 RACE
BLACK | 5 DATE OF BIRTH
MONTH DAY YEAR
7 31 62 | | 6 AGE (IN YEARS LAST BIRTHDAY)
21 YRS. | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Ann Arundel MD. | | | 10 CITY OR TOWN OF DEATH
LAUREL | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3360 Center Ave.
FOREST HAVEN | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b KIND OF BUSINESS OR INDUSTRY
— | | 13a INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b STREET ADDRESS
— Rt. 198 FOREST HAVEN 20810 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John Williams | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jacqueline Sweeney | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
— | | 17 INFORMANT
ADDRESS
5419 1st St. NW
WASH. DC 20011 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) STATUS EPILEPTICUS
3453
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC BRAIN SYNDROME
21 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) POST NATAL HEAD TRAUMA WITH SUBARACHNOID HEMORRHAGE 21 yrs | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 hr 30 min | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
PROFOUND MENTAL RETARDATION | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 10-21-80, 19 70, to 10-4, 19 83, that (I) (we) last saw the deceased alive on 10-4, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
Rolando V. Goco MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
10/9/83 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
ROLANDO V GOCO MD | | | | 22e ADDRESS
FOREST HAVEN, LAUREL, MD 20810 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b DATE
10-10-1983 | | 23c NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEM. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD P.C. MD. | | | |
| 24 FUNERAL DIRECTOR
NAME
W.W. CHAMBERS CO. | | ADDRESS
517 11th St SE
WASH. DC 20003 | | 25a DATE REC'D. BY REGISTRAR
13 1983 | | 25b REGISTRAR'S SIGNATURE
John J. Chambers | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 2 5 8 3 9
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|---|---|--|--|--------------------------------------|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST
<u>Loring Duane Wilson</u> | | | MONTH DAY YEAR
<u>10 24 83</u> | | | HOUR MIN.
<u>745 A</u> | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | | |
| <u>MALE</u> | <u>CAUCASIAN</u> | MONTH DAY YEAR
<u>8 29 46</u> | <u>37</u> YRS. | | | MONTHS DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| <u>MD</u> | <u>USA</u> | <u>Anne Arundel</u> MD. | | | <u>Anne Arundel</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <u>Annapolis</u> | <u>Anne Arundel General Hosp.</u> | | | <u>Public Info. Spec. Civil Service</u> | | | <u>INDUSTRY</u> | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| <u>MD</u> | <u>A.A.</u> | <u>Edgewater</u> | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | <u>902 Selby Blvd. 21037</u> | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | | | |
| FIRST MIDDLE LAST
<u>Clarence J. Wilson</u> | | | FIRST MIDDLE LAST
<u>Dorine Popham</u> | | | <u>1086 Americana Cir.</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | |
| <u>NO</u> | | | <u>214-48-1345</u> | | | <u>Dorine Wilson-Glen Burnie, MD 21061</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Upper Gastro-intestinal Bleeding</u> | | | | | | | | <u>12 HRS</u> | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | <u>3 Weeks</u> | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ERODING PHLEGMON</u> | | | | | | | | <u>1 month</u> | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Pancreatitis</u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>
AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9-25</u> 19 <u>83</u> , to <u>Present</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/24/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE
<u>Peter F. Verkhov</u> | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>10-24-83</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 22f. DATE REC'D. BY REGISTRAR | | | | |
| <u>PETER F. VERKHOV</u> | | | <u>1419 FOREST DR. Annapolis Md 21403</u> | | | <u>26 1983</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| <u>Burial</u> | | | <u>Oct. 26, 1983</u> | | | <u>St. Andrew the Fishermen</u> | | | <u>AA MD</u> | |
| 24. FUNERAL DIRECTOR
NAME | | | 24b. ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| <u>Taylor Funeral Chapel-Annapolis, MD</u> | | | <u>26 1983</u> | | | <u>George C. C. C.</u> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

John Brown

White

1821

X Home

1821's Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

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X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

1821's Home

X Home

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 3 2 5 8 4 0**
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret F Winters | | | 2a. DATE OF DEATH
MONTH 10 DAY 26 YEAR 83 | | 2b. HOUR
2 P.M. |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH 1 DAY 2 YEAR 43 | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Cty MD | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
PUBLIC SCHOOLS |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Severna Park | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
748 Ticonderoga Rd. 21146 | |
| 14. FATHER'S NAME
FIRST CECIL MIDDLE LAST BOWERS | | 15. MOTHER'S MAIDEN NAME
FIRST DOROTHY MIDDLE LAST WISEMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
213-38-8739 | | 17. INFORMANT ADDRESS
PHILIP A. WINTERS (SAME AS 13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased from 10/25 19 83 to 10/26 19 83 , that (I) (we) last saw the deceased alive on 10/25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Euse W Cole | | DEGREE
MD | | 22c. DATE SIGNED
10/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E.W. COLE | | 22e. ADDRESS
51 FRANKLIN ST ANNAP MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
OCT. 29, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE ANNE ARUNDEL MD. |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | ADDRESS
501 RITCHIE HWY. SEVERNA PARK, MD. | | 25a. DATE REC'D. BY REGISTRAR
OCT 31 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | |

85
53
35
20
1
9
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 3 2 5 8 4 1 | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Henry Wojcik | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
October 10, 1983 | | 2b. HOUR
M | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
November 26, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Warehousemen | | 12b. KIND OF BUSINESS OR INDUSTRY
Texaco Oil | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Wojcik | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Stella Krupinski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
WW 2 215-03-0647 | | 17. INFORMANT ADDRESS
Frances Wojcik same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>
4019
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe anemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>hypertension</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1964</u> , 19 <u>83</u> , to <u>Oct 10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Robert J. Abolins, M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
10-11-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT J. ABOLINS, M.D. | | | | | 22e. ADDRESS
400 CRAIN Hwy, N.W. Glen Burnie, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
13 Oct. 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley F.H. Glen Burnie MD. | | | | | 25a. DATE REC'D. BY REGISTRAR
OCT 17 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 20. DATE OF DEATH | | 21. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 20. DATE OF DEATH | | 21. HOUR | |
| Jethro T. Woolford | | Oct. 23, 1983 | | 3:00 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| male | white | Feb. 21, 1914 | 69 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Taylor's Isl. Md. | USA | | Anne Arundel Co. MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis | Anne Arundel General Hosp. | | mechanic | | automotive |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md. | A.A. Co. | Davidsonville | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 712 Appomatox Dr. 21035 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| Thomas Milbourne Woolford | Bertie Isabelle Horseman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| no | 214-05-0572 | Evelyn J. Woolford 712 Appomatox Dr. Davidsonville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC arrest | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) ASCVD, distal | | | | | Years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 1970, 19 to 1990, that (I) (we) last saw the deceased alive on 1990, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| A. B. | | | | 10/24 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 10/26/83 | | Glen Haven | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| CITY OR TOWN COUNTY STATE | | | | | |
| Glen Burnie, Md. A.A. Co. | | OCT 24 1983 | | John J. Conish | |
| 24. FUNERAL DIRECTOR NAME Hardesty that Funeral Home Annapolis, Md. 12 Ridgely Ave. | | | | | |

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